Supreme Court, U.S.
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No. _____

IN THE

Supreme Court of the United States

MAXANN C. FINK,

Petitioner

v.

JO ANN B. BARNHART,
COMMISSIONER OF SOCIAL SECURITY

Respondent

c/w

IDA J. ROCHESTER,

Petitioner

v.

JO ANN B. BARNHART,
COMMISSIONER OF SOCIAL SECURITY

Respondent

On Petition For Writ of Certiorari
To the Fifth Circuit Court of Appeals

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the court of appeals erred in holding that, in Social Security Disability claims, failure of the Social Security Administration to comply with 20 C.F.R. 404.1527(d)(2) and implementing regulations, which require that the Commissioner "make every reasonable effort to obtain from the individual's treating physician...all medical evidence, including diagnostic tests, necessary in order to properly make such determination," constitutes harmless error.

2. Whether the court of appeals erred in holding that this obligation can be shifted to Social Security Disability claimants.

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IN THE
SUPREME COURT OF THE UNITED STATES

PETITION FOR WRIT OF CERTIORARI

Petitioners respectfully pray that a writ of certiorari issue to review the judgment below:

OPINIONS BELOW

The opinion of the United States court of appeals appears at Appendix J to the petition and has been designated as unpublished, but may be found at 123 Fed.Appx. 146, 2005 WL 196726 (5th Dir.(LA)).

JURISDICTION

The date on which the United States Court of Appeals decided our case was January 31, 2005.

A timely petition for rehearing *en banc* was denied by the United States Court of Appeals on the following date: April 6, 2005, and a copy of the order denying rehearing appears at Appendix K.

The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

42 USC 423(d)(5)(B)

(B) In making any determination with respect to whether an individual is under a disability or continues to be under a disability, the Commissioner of Social Security shall consider all evidence available in such individual's case record, and shall develop a complete medical history of at least the preceding twelve months for any case in which a determination is made that the individual is not under a disability. In making any determination the Commissioner of Social Security shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.

STATEMENT OF THE CASE

Petitioner Maxann Fink filed an application for disability insurance benefits on July 22, 1998, alleging disability since June 30, 1986. She was denied initially and on reconsideration and had a hearing before an Administrative Law Judge, who issued a decision on September 25, 2000. That decision rejected the findings of the treating physicians in favor of the findings of a non-treating consultant and denied Petitioner benefits, stating that there was other work Petitioner could perform, so that she was not disabled. Petitioner requested review by the Appeals Council, but the decision was affirmed on June 7, 2002. Petitioner then appealed to the United States District Court, where the matter was referred to a Magistrate. The Magistrate, on August 11, 2003, recommended that there be judgment denying plaintiff's motion for summary judgment and granting defendant's motion for summary judgment. Plaintiff then filed an objection to the Magistrate's report and recommendation and a motion to stay proceedings, both of which were denied. Plaintiff then appealed to the Fifth Circuit Court of Appeals.

Petitioner Ida Rochester filed an application for disability insurance benefits on June 23, 1998, alleging disability since November 1, 1997. She was denied initially and on reconsideration and had a hearing before Administrative Law Judge E. Wilson Crump, II, who issued a decision on August 23, 2000. That decision rejected the findings of the treating physicians in favor of the findings of a non-treating consultant and denied petitioner benefits, stating that, as there was a substantial number of jobs petitioner could perform, she was not disabled. Petitioner requested review by the Appeals Council, but the decision was affirmed on October 17, 2002. Petitioner then appealed to the United States District Court. The Court below referred the matter to a Magistrate, who recommended that plaintiff's complaint be dismissed. Plaintiff

objected to the magistrate's report and recommendation, but the court accepted the findings and recommendation of the magistrate. Plaintiff Rochester then appealed to the Fifth Circuit Court of Appeals.

The two cases were consolidated, and, on January 31, 2005, the Fifth Circuit panel affirmed the decisions of the lower courts. Plaintiffs requested *en banc* rehearing, but that request was denied on April 6, 2005.

The basis for federal jurisdiction in the courts of first instance was 42 U.S.C. §401, *et. seq.*

For simplicity, petitioners will concisely state that the findings of their treating physicians, if accepted by respondent, would have resulted in a finding of disability for each. Instead, respondent sent petitioners to consultative examinations without soliciting the treating physicians to perform them, accepted the findings of a single non-treating examiner, and rejected the findings of both treating physicians in Fink and both treating psychiatrists (and a consulting psychiatrist) in Rochester without recontacting the treating physicians to attempt to resolve perceived inconsistencies or addressing the factors of 20 C.F.R. 404.1527(d)(2).

REASONS FOR GRANTING THE PETITION

Two years ago, in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), this Court compared the "treating physician rule" in ERISA cases to that of a portion (20 C.F.R. 404.1527) of the "treating physician rule" in Social Security disability cases. But 20 C.F.R. 404.1527 is but one of several regulations[1] implementing 42 USC 423(d)(5)(B), which was

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[1] 20 CFR 404.1500 *et. seq.* and 20 CFR 416.900 *et. seq.* For facility, only those regulations regarding Title II benefits, 20 CFR 404.1500 *et. seq.* will be addressed, though those regulations addressing Title XVI (SSI) are identical.

added to the Social Security Act as part of the Social Security Disability Benefits Reform Act of 1984[2],. These regulations, and 42 USC 423(d)(5)(B), have not yet been addressed by this Court, and there exists a division between the circuits regarding the enforcement of some.

In practice, 42 USC 423(d)(5)(B) and the regulations are uniformly ignored by the Social Security Administration (SSA) unless and until remedied by the Appeals Council on a case by case basis. For example, 42 USC 423(d)(5)(B) provides, in pertinent part:

> In making any determination the Commissioner of Social Security shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.

Accordingly, pursuant to instructions by the Second Circuit, 20 C.F.R. 404.1519h was enacted to provide:

> When in our judgment your treating physician or psychologist is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment, and generally furnishes complete and timely reports, your treating physician or psychologist will be the preferred source to do the purchased examination. Even if only a supplemental test is required, your treating physician or psychologist is ordinarily the preferred source.

But, in practice, petitioner urges that the treating physician is effectively solicited to perform the consultative examination in fewer than 5% of the cases. The number might very well be fewer than 1%, and counsel for petitioners

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[2] Pub. L. No. 98-460, 98 Stat. 1794 (1984)

requested of respondent on June 27, 2005 any statistical evidence of the frequency of treating physician consultative examinations. Instead, respondent routinely employs "key consultative examination providers" (See 20 CFR 404.1519s(e)), who tend to develop a relationship with the Administration, in preference to treating physicians. *Social Security Law and Practice*[3] at Sect. 37:74, p.63 pointedly notes that these consultative physicians "are employed and paid by the government for the purpose of defending against a disability claim...."

As more than four million Social Security Disability claims were decided in 2004,[4] the scope and import of the cases at bar can hardly be overstated. Petitioners urge that this constitutes an important question of federal law that should be settled by the Supreme Court.

SSA also introduced regulations to require that SSA recontact the treating physician by telephone or mail in an attempt to resolve perceived discrepancies prior to rejecting his findings in favor of those of a non-treating physician consultant (20 CFR 404.1512(e)(1)). "Enforcing the Agency's Duty to Recontact Physicians" was one of the three "Hot Topics in Federal Court Litigation" at the November 2004 conference of the National Organization of Social Security Claimants' Representatives. There is a split between the Circuits on this issue, which must be resolved. The Fifth Circuit, in the cases below, held that failure to comply with this regulation constitutes harmless error. But in the Eighth Circuit cases of *Bowman v. Barnhart*, 310 F.3d 1080 (8th Cir. 11/20/2002) and *O'Donnell v. Barnhart*, 318 F.3d 811 (8th Cir. 02/07/2003), ¶32, and in the Tenth Circuit cases of *White v. Massanari*, 287 F.3d

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[3] Travers, Timothy E., ed., *Social Security Law and Practice*, Clark, Boardman, Callaghan (Deerfield, IL., 1993).

[4] U. S. Office of Disability Programs, January 2005

903 (10th Cir. 2001) and *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004), the courts of appeals remanded for failure to comply with 20 CFR 404.1512(e)(1). This conflict between the Circuits must be resolved.

A third such regulation requires SSA to consider the factors of 20 C.F.R. 404.1527(d)(2), regarding the nature of the competing treating and non-treating physician opinions, prior to rejecting the findings of the treating physician. Again, the Circuits are split. The Fifth Circuit, in the cases below, found failure to comply with this regulation to be harmless error. The Second Circuit in *Clark v. Commissioner of Social Security*, 143 F.3d 115, 118 (2d Cir. 1998), the Sixth Circuit in *Wilson v. Commissioner of Social Sec.*, 378 F.3d 541 (6th Cir. 2004), and the Tenth Circuit, in *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004) and *Goatcher v. U.S. Department of Health & Human Servs.*, 52 F.3d 288, 290 (10th Cir. 1995) all found failure to consider the factors of 20 C.F.R. 404.1527(d)(2) to be reversible error. This conflict between the Circuits must also be resolved.

In the cases at bar, the Fifth Circuit Court of Appeals found that failure to comply with 42 USC 423(d)(5)(B)and implementing regulations constituted "harmless error." But the Sixth Circuit, in *Wilson v. Commissioner of Social Sec.*, 378 F.3d 541 (6th Cir. 2004) addressing the same argument, found that failure of respondent to follow its own procedural regulations, particularly 20 C.F.R. 404.1527(d)(2), constitutes deprivation of a "substantial right" and is reversible error. This division between the Circuits must also be resolved.

Finally, the Fifth Circuit, in the cases below, found that the obligation to develop the record can be shifted to claimants, presumably even unrepresented claimants. The Tenth Circuit, in *White v. Barnhart*, 287 F.3d 903, 908 (10th Cir. 2001) and *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004) expressly rejected this argument. This conflict between the Circuits must also be resolved.

Thus, at least four Circuits are in conflict on matters that directly affect millions of disabled claimants each year. Accordingly, petitioners respectfully urge that it is appropriate that the Supreme Court resolve these issues, which are so important to millions of disabled Americans each year.

The Congress has instructed the Social Security Administration in the use of treating physicians by amending the Act. Only the Judiciary can enforce the will of the Congress.

1. Whether the court of appeals erred in holding that, in Social Security Disability claims, failure of the Social Security Administration to comply with 20 C.F.R. 404.1527(d)(2) and implementing regulations, which require that the Commissioner "make every reasonable effort to obtain from the individual's treating physician...all medical evidence, including diagnostic tests, necessary in order to properly make such determination," constitutes harmless error.

Prior to 1984, the Social Security Act contained provisions for consultative examinations by non-treating physicians but no restrictions on their use.

In 1982, Respondent was engaged in an accelerated program of review of eligibility for recipients of Social Security Disability benefits. The program resulted in an avalanche of complaints to Congress about the methods of evaluation. In the 97th Congress, the Senate Finance Committee heard such complaints as that of Ethel A. Kage, of Reed City, Michigan, whose husband had died, she felt, partially as a result of improper termination of his benefits due to deficiencies in the system of disability evaluation. Her main complaint was that the Social Security Administration "ignored" the findings of the physician who had treated her husband for a number of years and instead relied upon the findings of a consultative physician

who had performed a brief exam.[5]

Also submitted into the Congressional Record was a letter from Sen. John Heinz, Chairman of the Special Committee on Aging, which stated:

> Psychiatric consultants have publicly complained that the brief time allotted to them to evaluate the patient's condition is altogether insufficient to reach a valid conclusion about the individual's mental health, and the American Psychiatric Association (APA) has pointed out that the consultations are too cursory and too brief to be of value.[6]

Senator Cohen noted that the Act did not even provide the deference to the treating physician accorded in workers' compensation cases.[7]

In 1984, the Senate finally passed SB 476, subsequently including its provisions as an amendment to HR 3755, which it passed 96-4. The provisions of that amendment subsequently became 42 USC 423(d)(5)(B).

Petitioners urge that the proper interpretation of that amendment includes the following:

1. Consultative exams are designed to be used by SSA only where there is conflicting medical evidence that it is necessary to resolve in order to make an eligibility determination. Instead, in many cases, they are in fact ordered routinely, **used as a counterpoint to the report of the treating physician**, and relied upon almost exclusively.

2. The amendment directs SSA to give great credence to

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[5] Hearing before the Committee on Finance of the United States Senate, Ninety-Seventh Congress, Second Session, August 18, 1982, p.54.

[6] Hearing before the Committee on Finance of the United States Senate, Ninety-Seventh Congress, Second Session, August 18, 1982, p.17.

[7] *Ibid.*

the findings and reports of a beneficiary's treating physician who more often than not has lived closely with that subject's disabilities and through his/her hands-on experience has developed a more thorough knowledge of the illness than the consultative examiners who may give no more than 30 minutes for the evaluation.

3. SSA complains that treating physicians too often provide mere opinion without the necessary test results or specific medical findings upon which the disability examiner can make the necessary determination. This amendment is telling SSA to ask the proper questions of the treating physician so it can elicit a helpful response. If there are tests to be conducted and scientific assessments made of an individual's functional capabilities, SSA should work with the treating physician to get those answers. Under the provisions in this amendment, we should witness far fewer consultative exams and more thorough and factually based reports by treating physicians.

Should the Court be inclined to question this interpretation, it should first note that the foregoing was taken, almost verbatim and specifically including the phrase "used as a counterpoint to the report of the treating physician," from the remarks of the lead author[8] of S.B. 476, Sen. Carl Levin, to the full Senate in urging the amendment just prior to its passage.[9]

This is now the law of the land. 42 USC 423(d)(5)(B) provides:

> In making any determination the Commissioner of Social Security shall make **every reasonable effort** to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic test, necessary in order to properly

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[8] With Sen. William S. Cohen of Maine

[9] See Appendix "L" for the full text.

> make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis. (Emphasis supplied)

That is, respondent's obligation to a claimant is such that it must try **every** reasonable means to base its determination on the findings and opinions of the treating physicians until it can be fairly said that it would be un**reasonable** to ask it to make further **effort**. Only then can respondent consider findings of a non-treating physician. Claimant urges this to be clearly the most insightful means of determining a claimant's true condition. But, wise or unwise, prudent or imprudent, that is the law this Court now interprets.

In *Schisler v. Heckler*, 787 F.2d 76 (2nd Cir. 1986), the Second Circuit noted non-acquiescence with the newly enacted "treating physician rule"and directed respondent to expeditiously "state in relevant publications...that adjudicators...are to apply the treating physician rule of this circuit." In response, respondent offered a proposed Social Security Ruling (SSR) that was rejected by the Second Circuit in *Schisler v. Bowen*, 851 F.2d 43 (2nd Cir. 1988). The Second Circuit offered instead an approved SSR.

Finally, the Social Security Administration enacted in 1991 new regulations on consultative and treating physicians essentially adopting the proposals of the Second Circuit. Included among these are 20 CFR 404.1512 and 404.1527(d)(2).

20 CFR 404.1512(e) and (f) provide that the consultative examination shall be ordered only if still necessary **after recontacting the treating physician**. The relevant portions of these regulations read as follows:

> (e) Recontacting medical sources. When the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled, we will need additional information to reach a determination or a

> decision. To obtain the information, we will take the following actions.
> (1) We will first recontact your treating physician or psychologist or other medical source to determine whether the additional information we need is readily available. **We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques.**
>
> . . .
>
> (f) Need for consultative examination. If the information we need is not readily available from the records of your medical treatment source, or we are unable to seek clarification from your medical source, we will ask you to attend one or more consultative examinations at our expense. See 404.1517 through 404.1519 for the rules governing the consultative examination process. Generally, **we will not request a consultative examination until we have made <u>every reasonable effort</u> to obtain evidence from your own medical sources**.
>
> . . .
>
> **We will not evaluate this evidence until we have made <u>every reasonable effort</u> to obtain evidence from your medical sources**. (Emphasis supplied)

Counsel for Petitioners has repeatedly obtained remands from the district courts over the past decade when ALJs have failed to comply with the criteria of 20 CFR 404.1512(e)(1). All of these cases have been unreported, though a number of them were summarized in *Lewis v. Chater*, 1996 WL 43111 (E.D. La. July 31, 1996) (No.Civ.A.95-3402) (attached to plaintiff's Fifth Circuit brief in Fink).

The Fifth Circuit took its first step toward enforcement of 42 USC 423(d)(5)(B) and implementing regulations in *Newton v. Apfel*, 209 F.3d 448 (5th Cir. 2000). More recently, in the Eighth Circuit cases of *Bowman v. Barnhart*, 310 F.3d 1080 (8th Cir. 11/20/2002) and *O'Donnell v. Barnhart*, 318 F.3d 811 (8th Cir. 02/07/2003), ¶32, and in the Tenth Circuit cases of *White v. Massanari*, 287 F.3d 903 (10th Cir. 2001) and *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004), the courts of appeals remanded for failure to comply with 20 CFR 404.1512(e)(1).

The amendment to the Act and the subsequent regulations do not remove from the ALJ the authority to make the final evaluation of the evidence. It merely provides procedures to ensure that every reasonable effort is made to turn to the treating physician(s) to obtain the medical evidence upon which the decision is based. When the treating physician(s) cannot provide that information, a consultative examination is ordered, employing a treating physician if he is qualified and willing (20 CFR 404.1519h) or a non-treating physician if he is not.

But the consultative examination cannot be ordered until the treating physician is contacted in an attempt to obtain the necessary information, including an explanation of perceived discrepancies.

And, as noted, 42 USC 423(d)(5)(B) and 20 CFR 404.1512(f) prohibit even considering evidence from a consulting examiner until "every reasonable effort" is made to obtain the requisite information from the treating physician through recontact as provided in 20 CFR 404.1512(e)(1).

Respondent has regularly ignored the regulations and the mandate of 42 USC 423(d)(5)(B), and, presumably, the ALJs are not instructed in their implementation. Otherwise, it is unlikely that the ALJ in *Passaro v. Barnhart*, E.D.LA. No.04-1300, would have openly expressed his disdain for the Reform Act as follows:

Q Well, you present me with a difficult case, ma'am. Okay. I -- there are doctors here who say that you know basically, you're totally incapacitated.

A And well, I do agree.

Q And then I have a consultative exam from Dr. Forette, which basically says, he can't find very much wrong with you at all and you need to go to work.

. . .

A I mean this is three doctors to one.

Q Well -- yeah. That's true. So maybe it should -- I'm not sure I'm supposed to evaluate on the vote basis.

A Well, yeah. I mean these doctors have known me since the wreck happened. One of the doctors has been my doctor since I had been 19 years old. And he knows me.

Q Well, hat's (sic) true.

A And I'm to somebody just to -- I sit around and it's very, it's boring. And it's --

Q The only problem I have to discover with these, these -- when the treating physicians give these kind of summary opinions. Is that a lot of times they want the best for their patient. And they're basically become patient advocates and they strew (sic) things in favor of the patient. Which is I think natural for them to do. But what it means is that I don't get an objective assessment from them. Because they want to you know, see the -- see their patient get what they want. Which is natural. Because they're the patient. But I, what I have to decide is, is whether this is an objective medical opinion, based on medical records that support it or whether this is basically patient advocacy. If you understand what I mean.

A I did not understand that. What did you mean?

Q What I mean is, is that I got a lot of treating doctors who will basically give reports that are not

accurate because they want to do a favor.

A Keep me coming back.

Q Well, they want to do a favor for their, their patient. And if their patients want it, then they'll say it whether it's true or not.

That ALJ rejected the findings of the treating physicians. The United States District Court for the Eastern District of Louisiana rejected the recommendation of the U.S. Magistrate and remanded the case for rehearing, which is now pending. Nevertheless, the foregoing demonstrates that the ALJs do not feel constrained by 42 USC 423(d)(5)(B).

In the cases at bar, accepting the findings of the treating physicians would have resulted in a finding of disability. But, in rejecting those findings, the respondent:

1. Ordered consultative examinations without first attempting to recontact the treating physician to obtain the needed information, in violation of 20 CFR 404.1512(e)(1);

2. Ordered consultative examinations without soliciting the treating physician to perform the examination, in violation of 20 CFR 404.1519h;

3. Not only considered, but also relied upon, the findings of consulting examiners without first recontacting the treating physicians to resolve a perceived conflict between office notes and findings on a medical assessment form and to determine the basis for the treating physician's endorsement of symptoms which the ALJ considered not supported by clinical findings, in violation of 20 CFR 404.1512(f);

4. Rejected the findings of the treating physicians without recontacting them as required by 20 CFR 404.1512(e)(1); and

5. Rejected the findings of the treating physicians without considering the criteria of 20 C.F.R. 404.1527(d)(2).

All of which violate, as well, the instructions and intent of 42 USC 423(d)(5)(B).

Finally, the ALJ's decision in Rochester offered no reasons whatever for rejecting Dr. Holden's findings. In

Goodley v. Harris, 608 F.2d 234, 236 (5th Cir. 1979) the Court of Appeals held that an ALJ may not arbitrarily choose to ignore uncontroverted medical evidence. And 20 C.F.R. 404.1527(d)(2) states, "We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion." By failing to provide any reasons, much less "good reasons," for rejecting Dr. Holden's findings, the ALJ committed reversible error.

It is difficult to imagine in the instant cases how the SSA could have controverted the treating physician rule and the attendant regulations more than it did. In each case, had the appropriate law and regulations been followed, it is likely, not just possible, that a different decision would have resulted. Had appropriate weight been afforded the opinions of the treating physicians, a different decision definitely would have resulted.

Yet the Fifth Circuit held that failure to comply with the Act and regulations constitutes harmless error, stating, "Because Fink and Rochester were afforded the opportunity to supplement their respective records with additional medical reports from their treating physicians, we hold that any procedural errors committed by the commissioner were harmless and did not affect Fink's or Rochester's substantial rights. See Morris v. Bowen 864 F.2d 333, 335 (5th Cir. 1988)."

But a claimant cannot know how to supplement the record to satisfy an ALJ's reservations about treating physician opinions unless and until the ALJ articulates them. And in the rare event that the ALJ does provide sufficient specificity in his decision to afford supplementation, is the claimant constrained to submit the additional evidence to the Appeals Council and wait some two years for redress? And, generally, is not such a holding clearly inconsistent with Congressional intent?

The Fifth Circuit puts the "harmless error" rule in perspective in cases such as *Frank v. Barnhart*, 326 F.3d 618 (5th Cir. 2003) and *Anderson v. Sullivan*, 887 F.2d 630, 634 (5th Cir. 1989) when it explained, "The major policy underlying the

harmless error rule is to preserve judgments and to avoid waste of time."

In *Morris*, claimant had been unable to work around machinery. A vocational expert subsequently found a number of jobs claimant could perform, two of which, "lawn care" and "grass cutting," required work around machinery. However, the remainder of the jobs found were within the limitations imposed by the ALJ, so that it did not matter whether the claimant could work on lawns. The Court stated that:

> [P]rocedural perfection in administrative proceedings is not required. This court will not vacate a judgment unless the substantial rights of a party have been affected. The procedural improprieties alleged by Morris will therefore constitute a basis for remand only if such improprieties would cast into doubt the existence of substantial evidence to support the ALJ's decision.

Thus the acceptance by the ALJ of improper jobs did not prejudice Morris in any way, as the ALJ correctly found other jobs he could perform. That is hardly equivalent to the situation in the case at bar. The total abandonment of the implementing regulations of and the provisions of 42 USC 423(d)(5)(B) constitutes much more than a bare lack of "procedural perfection." It constitutes a flagrant violation of a claimant's right to have his or her treating physician provide the evidence on which a determination of eligibility for disability benefits is based, a right conferred by the same body that drafted the Social Security Act, the U. S. Congress.

Moreover, if failure to comply with the regulations can be corrected by allowing opportunity to supplement the records, why does HALLEX I-5-310 Attachment IV provide:

> 10. How should the Appeals Council respond to a challenge to the admissibility of a CE report obtained at the hearing level without first making every reasonable effort to obtain the needed information from the

> claimant's medical source(s)?
> As indicated above, we are precluded from evaluating a CE report obtained pursuant to § 404.1512(f)/416.912(f) until the needed information is received from the claimant's medical source(s) or every reasonable effort has been made to obtain it. **If a decision shows that the ALJ evaluated a CE report before the needed information was received or every reasonable effort had been made, there is an error of law, and the Appeals Council will grant review to take appropriate corrective action.** (emphasis supplied)

Counsel for Petitioners has obtained a number of remands from the Appeals Council for failure to comply with 20 CFR 404.1512(e)(1) and related regulations. *In re Jerry Edwards* (attached to Plaintiff's brief in Fink), is selected as representative, as there was a conflicting opinion from a non-treating source. In *Edwards*, the Appeals Council remanded, saying:

> In accordance with 20 CFR 404.1512(e), when the reports from a treating physician do not contain all of the necessary information to support the ultimate assessment provide(d) by the physician, the treating source must be recontacted and asked to provide a new report, a more detailed report, or copies of additional existing medical information. While unreasoned or undocumented opinions by treating physicians cannot be determinative, section 404.1512(e) provides that an effort must be made to obtain evidence from treating sources whose opinions lack the appropriate documentation or reasoning.

If, in the opinion of respondent's own Appeals Council, the availability of supplementation of the record does not obviate the need for remand, then, by respondent's own decisions, failure to make every reasonable effort obviously

constitutes reversible error.

The comments in the Federal Register accompanying the promulgation of 20 CFR §§ 404.1512 and 404.1527 clarify the Commissioner's intention to make recontact with the treating source ***mandatory***, rather than permissive, in order to afford special status to treating sources:

> Recontact with treating sources to complete the case record and to resolve any inconsistencies in the evidence is one of the principal provisions of this set of rules. See Sections 404.1512(d) and 416.912(d) of these final regulations. Far from being restrictive, the intent of these rules is to **require** such contacts.56 Fed. Reg. 36950-1 (August 1, 1991) (Emphasis added).

If the right to have the opinions of treating physicians serve as the basis for a determination of disability is not a "substantial right," then the Fifth Circuit panel is correct, and the U.S. Congress is wrong, for Congress considered the right sufficiently substantial to amend the Social Security Act to assure that right to claimants. To the best of petitioners' knowledge, this is the only occasion on which Congress felt strongly enough about a question of evidence to Amend the Social Security Act. They amended it to ensure that decisions are based on information from treating physicians and specifically not from non-treating examiners used as a "counterpoint" to the report of the treating physician.

The Fifth Circuit also distinguished the cases at bar from *Newton v. Apfel*, 209 F.3d 448 (5th Cir. 2000) by noting that *Newton* was a case in which there were no contradictory opinions from non-treating physicians. Of course, petitioner noted that distinction in Fink's original brief (p.38) and urged the expansion of *Newton* to the cases at bar. But there is no basis for that distinction, and the legislative history demonstrates that it was precisely cases in which a non-treating examiner was "used as a counterpoint" to the treating physicians for which the Act was amended.

Moreover, the Fifth Circuit does not deny the applicability of the Act and regulations to the cases at bar, so that it, in fact, does expand the *Newton* decision to the instant cases. Thus, if the availability of supplementation of the record did not render the error harmless in *Newton*, how can it be harmless in the cases at bar?

There is also a split in the Circuits as to the need for an ALJ to address the factors of 20 C.F.R. 404.1527(d)(2) (See *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004)), ¶30, in which the Tenth Circuit remanded for failure to address the factors of 20 C.F.R. 404.1527(d)(2))

Additionally, the *Newton* court said:

> Several federal courts have concluded that an ALJ is required to consider each of the § 404.1527(d) factors when the ALJ intends to reject or give little weight to a treating specialist's opinion. See *Clark v. Commissioner of Social Security*, 143 F.3d 115, 118 (2d Cir. 1998); *Goatcher v. U.S. Department of Health & Human Servs.*, 52 F.3d 288, 290 (10th Cir. 1995); *Dwyer v. Apfel*, 23 F. Supp. 2d 223, 228 (N.D.N.Y. 1998); *Amidon v. Apfel*, 3 F. Supp. 2d 350, 355-56 (W.D.N.Y. 1998); *McDonald v. Apfel*, No. CA 3-97-CV-2035R, 1998 WL 159938, *8 (N.D. Tex. Mar. 31, 1998). This court now similarly holds that an ALJ is required to consider each of the § 404.1527(d) factors before declining to give any weight to the opinions of the claimant's treating specialist. The ALJ failed to perform this analysis, which should be conducted on remand.

The foregoing makes no distinctions between cases wherein there are or are not contrary opinions by consulting physicians, nor has anyone proposed any basis for such a distinction, nor do other Circuits make such distinction. How would the ability to supplement the record render failure to consider the factors of 20 C.F.R. 404.1527(d)(2) harmless? And how does the ability to supplement the record render

harmless the failure to employ a treating physician for a consultative examination?

Respondent offered the same "harmless error" argument in *Wilson v. Commissioner of Social Sec.*, 378 F.3d 541 (6th Cir. 2004). Because petitioners consider the opinion to be dispositive, much of it is quoted herein:

> It is an elemental principle of administrative law that agencies are bound to follow their own regulations. As the Ninth Circuit well summarized in applying this principle:
>
> [30] The Supreme Court has long recognized that a federal agency is obliged to abide by the regulations it promulgates. See *Vitarelli v. Seaton*, 359 U.S. 535, 545 (1959); *Service v. Dulles*, 354 U.S. 363, 372 (1957); *Accardi v. Shaughnessy*, 347 U.S. 260, 267 (1954). An agency's failure to follow its own regulations "tends to cause unjust discrimination and deny adequate notice" and consequently may result in a violation of an individual's constitutional right to due process. Where a prescribed procedure is intended to protect the interests of a party before the agency, "even though generous beyond the requirements that bind such agency, that procedure must be scrupulously observed." *Vitarelli*, 359 U.S. at 547 (Frankfurter, J., concurring); see also Note, Violations by Agencies of Their Own Regulations, 87 Harv. L. Rev. 629, 630 (1974) (observing that agency violations of regulations promulgated to provide parties with procedural safeguards generally have been invalidated by courts).
>
> [31] *Sameena, Inc. v. United States Air Force*, 147 F.3d 1148, 1153 (9th Cir. 1998) (parallel citations and circuit court citations omitted). Consistent with this principle, courts have remanded the Commissioner's decisions when they have failed to articulate "good reasons" for not crediting the opinion of a treating

source, as §§ 1527(d)(2) requires. See, e.g., *Newton v. Apfel*, 209 F.3d 448, 456 (5th Cir. 2000); *Snell*, 177 F.3d at 134; see also *Halloran*, 362 F.3d at 33 ("We do not hesitate to remand when the Commissioner has not provided ''good reasons' for the weight given to a treating physician's opinion and we will continue remanding when we encounter opinions from ALJ's that do not comprehensively set forth the reasons for the weight assigned to a treating physician's opinion.").

...

[34] In particular, the ALJ...did not explain its application of the factors listed in 20 C.F.R. §§ 404.1527(d)(2) to determine the weight given to DeWys's opinion. Reversal is therefore required.

[35] The ALJ's failure to give "good reasons" for not crediting DeWys does not constitute harmless error, notwithstanding the district court's reasoning and the Commissioner's argument on appeal....Echoing the district court, the Commissioner contends that, assuming for argument's sake that the ALJ misread DeWys's opinion, this mistake qualifies as harmless error. The Commissioner asserts that the ALJ's rejection of DeWys's opinion is supported by substantial evidence, as the ALJ "could" have relied on evidence in the record--namely, Wilson's testimony and the opinions of two consulting physicians, which, according to the Commissioner, contradict DeWys's opinion–to reject the opinion.

[36] The argument is not persuasive in the context of this case. A court cannot excuse the denial of a mandatory procedural protection simply because, as the Commissioner urges, there is sufficient evidence in the record for the ALJ to discount the treating source's opinion and, thus, a different outcome on remand is unlikely. "[A] procedural error is not made harmless

simply because [the aggrieved party] appears to have had little chance of success on the merits anyway." *Mazaleski v. Treusdell*, 562 F.2d 701, 719 n.41; see also *Ingalls Shipbuilding, Inc. v. Dir., Office of Workers' Comp. Programs*, 102 F.3d 1385, 1390 (5th Cir. 1996). **To hold otherwise, and to recognize substantial evidence as a defense to non-compliance with §§ 1527(d)(2), would afford the Commissioner the ability the violate the regulation with impunity and render the protections promised therein illusory.** The general administrative law rule, after all, is for a reviewing court, in addition to whatever substantive factual or legal review is appropriate, to "set aside agency action ... found to be . . . without observance of procedure required by law." Administrative Procedure Act, 5 U.S.C. §§ 706(2)(D) (2001).

[37] Our conclusion is consistent with the statement in *Connor v. United States Civil Service Commission*, 721 F.2d 1054, 1056 (6th Cir. 1983), that "an agency's violation of its procedural rules will not result in reversible error absent a showing that the claimant has been prejudiced on the merits or deprived of substantial rights because of the agency's procedural lapses" (emphasis added). A procedural right must generally be understood as "substantial" in the context of this statement when the regulation is intended to confer a procedural protection on the party invoking it. **The Supreme Court has recognized the distinction between regulations "intended primarily to confer important procedural benefits upon individuals" and regulations "adopted for the orderly transaction of business before [the agency]."** *Am. Farm Lines v. Black Ball Freight Serv.*, 397 U.S. 532, 538-39 (1970) (internal quotation marks omitted). In the former case, the regulation bestows a "substantial right" on parties

> before the agency, and "it is incumbent upon agencies to follow their own procedures . . . even where the internal procedures are possibly more rigorous than otherwise would be required." *Morton v. Ruiz*, 415 U.S. 199, 235 (1974); see also *Vitarelli v. Seaton*, 359 U.S. 535, 540 (1959); *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260, 267 (1954). In contrast, in the case of procedural rules "adopted for the orderly transaction of business," an agency has the discretion "to relax or modify its procedural rules" and such action "is not reviewable except upon a showing of substantial prejudice to the complaining party." *Am. Farm Lines*, 397 U.S. at 539 (quotation omitted). **Section 1527(d)(2) falls in the former category, creating an important procedural safeguard for claimants for disability benefits.** *Snell*, 177 F.3d at 134.(emphasis supplied)

It is noteworthy that the *Wilson* Court did not even consider the mandate of 42 USC 423(d)(5)(B). Certainly, if respondent cannot ignore her own regulations, she cannot ignore the directive of the U.S. Congress.

2. Whether the court of appeals erred in holding that this obligation can be shifted to claimants.

Moreover, in the instant cases the Fifth Circuit effectively delegated to the petitioners the obligation of developing information that would satisfy the ALJ's reservations or perceived inconsistencies, though 20 CFR 404.1512(e)(1) expressly states that respondent will undertake that task. This is inconsistent with the express holding of the Tenth Circuit in *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004):

> [32] Third, the ALJ's statement that Dr. Baca's records did not give a reason for his opinion that claimant is unable to work triggered the ALJ's duty to seek further development of the record before rejecting the opinion. If evidence from the claimant's treating doctor is

> inadequate to determine if the claimant is disabled, an ALJ is required to recontact a medical source, including a treating physician, to determine if additional needed information is readily available. See 20 C.F.R. §§§§ 404.1512(e)(1) and 416.912(e)(1) ("We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques."); see also *McGoffin*, 288 F.3d at 1252 (holding ALJ had obligation to recontact treating physician if validity of his report open to question). **The responsibility to see that this duty is fulfilled belongs entirely to the ALJ; it is not part of the claimant's burden.** *White v. Barnhart*, 287 F.3d 903, 908 (10th Cir. 2001). If the ALJ concluded that Dr. Baca failed to provide sufficient support for his conclusions about claimant's mental limitations, the severity of those limitations, the effect of those limitations on her ability to work, or the effect of prescribed medications on her ability to work, he should have contacted Dr. Baca for clarification of his opinion before rejecting it. The ALJ did not do so.(emphasis supplied)

The decision in *White v. Barnhart* is at least as direct in finding that the respondent cannot shift her burden to the plaintiffs, stating:

> Ms. White claims that the ALJ should have recontacted Dr. Fanning to obtain a more detailed medical examination and disability assessment. The Commissioner responds by blaming Ms. White for failing to carry out her "responsibility to bring forth evidence related to the disability that she claims." Appellee's Br. at 25. If by this accusation the

> Commissioner suggests that the ALJ's duty to recontact a treating physician is contingent on the some further act by the claimant, the Commissioner is wrong. The Commissioner, under the governing regulations, must recontact a treating physician when the information the doctor provides is "inadequate . . . to determine whether you [the claimant] are disabled." 20 C. F. R. §§ 416.912(e). The regulations do not burden the claimant with any additional obligation in this regard once the record is deemed "inadequate."

In the instant cases, the respondent found the evidence so "inadequate" as to require consultative examinations. She should first have recontacted the treating physician(s) to attempt to reconcile perceived inconsistencies or inadequacies.

CONCLUSION

The United States Congress understands the importance of Social Security Disability claims. For these unfortunate claimants, the decision determines whether they will be able to relieve the burden on their families with a minimal existence and whether they will be able to have their medical needs properly cared for. Because of their numbers, the decision making system must be somewhat informal. Thus, *Lidy v. Sullivan*, 911 F.2d 1075 (5th Cir. 1990) notwithstanding, the few requests for subpoenas of physicians filed by undersigned counsel have been uniformly refused. Moreover, Social Security disability claimants are notoriously unable to pay the fees of expert testimony, so that treating physicians are not available for examination by the ALJ.

Accordingly, if an ALJ should have questions of the treating physician, he would be constrained to call him (even doctors talk to judges) or send written questions. The regulations now require it, even when the ALJ is reluctant. If there are perceived deficiencies in the opinions of treating physicians, though it may be an additional burden to the ALJ to contact the treating physician by telephone or by mail, it is one which must be borne. One cannot simply say, "It would have been too much trouble to ask the treating physician for an explanation."

It is impractical to ask of claimants, especially unrepresented claimants, that they divine the questions that would satisfy the reservations of the ALJ and solicit the treating physicians to answer them. Claimants can barely convince physicians to execute medical assessment forms. Physicians are much less likely to ignore inquiries from federal judges.

The total abandonment of the implementing regulations and the provisions of 42 USC 423(d)(5)(B) constitutes much more than a bare lack of "procedural perfection." It constitutes a flagrant violation of a claimant's right to have his or her

treating physician provide the evidence on which a determination of eligibility for disability benefits is based, a right conferred by the same body that drafted the Social Security Act, the U. S. Congress. Failure to reverse the decision below would tell Congress that they can pass all the laws regarding a determination of disability they wish to pass, the Social Security Administration will ignore those laws, seek and rely upon whatever opinions it wishes, usually from "key providers" (See 20 CFR 404.1519s(e)), and do so with impunity, secure in the knowledge that the judiciary will find that the "harmless error" or lack of "procedural perfection" does not invalidate the determination.

If the courts will not enforce the intent of Congress, who will?

The petition for a writ of certiorari should be granted.

Respectfully submitted,

PAUL BRIAN SPURLOCK
Attorney for Petitioners
DATE: July 4, 2005

Supreme Court, U.S.
FILED
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05- 58 JUL 5 - 2005
No. _____ OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

MAXANN C. FINK,

Petitioner

v.

JO ANN B. BARNHART,
COMMISSIONER OF SOCIAL SECURITY

Respondent

c/w

IDA J. ROCHESTER,

Petitioner

v.

JO ANN B. BARNHART,
COMMISSIONER OF SOCIAL SECURITY

Respondent

On Petition For Writ of Certiorari
To the Fifth Circuit Court of Appeals

APPENDICES TO PETITION FOR WRIT OF CERTIORARI

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APPENDIX A:

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals
DECISION

IN THE CASE OF CLAIM FOR

Period of Disability,
Disability Insurance Benefits, &
Supplemental Security Income

MAXANN C. FINK 436-94-1596
(Wage Earner) (Social Security Number)

Claimant filed concurrent applications for disability insurance benefits and supplemental security income with a protective filing date of July 22, 1998. (Ex 6D/1). Following denial of the claims initially and on reconsideration, she filed a timely request for hearing. She testified at the hearing, which was held in Metairie, Louisiana on July 26, 2000. She was represented by an attorney, Clydia Davenport. Thomas Meunier testified as vocational expert. Leon Weisberg testified as medical expert.

Claimant is 44 years old. She has a GED and has not worked in at least the past 15 years. She testified that she last worked in 1982 and received worker's compensation benefits for several years thereafter. In her application documents, she alleged disability since September 19, 1980 due to three ruptured discs in her back and two ruptured discs in her neck.

There is no evidence of substantial gainful activity after the alleged onset date. Claimant's wage records reflect only minimal earnings in 1981 and 1991. (Ex. 8D)

Claimant's insured status under the Act expired on June

30, 1986. Therefore, to be entitled to benefits on her claim for disability insurance benefits under Title II of the Act, disability must be established on or before June 30, 1986.

The medical evidence indicates that Claimant was under the treatment of Dr. Gessner (orthopedist) from 1981 to December 1986. On January 9, 1981, she reported that she sustained an injury to her low back a few months earlier. According to Dr. Gessner, x-rays showed spina bifida and a slight degree of spondylolisthesis at L5-S1. Examination indicated positive straight leg raising on the right at 45 degrees. By February 1, 1983, Claimant was complaining of intermittent low back pain and leg pain which was worse on the left. She had mild spasm on examination of the low back. Conservative treatment was recommended. Dr. Gessner commented that, if Claimant's pain got to the point where she needed medication on a routine basis, he would have to proceed with surgery (and she did not subsequently undergo any back surgery). Dr. Gessner did not think that Claimant stated that Claimant was not capable of returning to her "usual" work (which required heavy exertion (Ex. 1E/6) However, he believed that she could perform "sedentary" secretarial-type work. On Marc 15, 1983, Claimant complained of low back discomfort. The diagnostic impression was herniated disc and slight spondylolisthesis (the previously noted spina bifida was no longer noted and was apparently not thought to be significant). From March through December 1983, Claimant's complaints included weakness in the left leg, pain in the right leg, and numbness in both legs; however, neurological examination remained intact. The clinical findings were basically limited to mild muscle spasm and positive straight leg raise. She was continued on Soma. Dr. Gessner reiterated that she could do sedentary-type work. The diagnostic impression became only herniated disc (indicating that the slight spondylolisthesis was not thought to be significant). In March 1984, Dr. Gessner started Claimant on physiotherapy (heat, massage,

ultrasound). On July 24, 1984, she was complaining of discomfort which was not to the point where surgery was indicated. Examination on November 14, 1984 indicated mild spasm. In January 1985, she was taken off all medication due to pregnancy. On May 7, 1985, Dr. Gessner wrote that Claimant was "disabled from work activity" secondary to her low back, but provided no supportive findings and did not say whether he was referring to all work or only her usual work. (If he no longer believed that she could perform sedentary-type work, his records do not provide any reason for the change in opinion.) On July 3, 1985, Claimant complained of back pain and numbness in hands. Dr. Gessner's records do not reflect prior or subsequent complaints regarding the hands. On February 19, 1986, Claimant complained of increased pain, but there was no mention of any clinical findings. On June 25, 1986, Claimant complained of right-sided neck, shoulder, arm, and leg pain after a motor vehicle accident. The impression was cervical strain and contusion. On follow-up on July 8, 1986, she was said to be improved. On December 16, 1986, Dr. Gessner said that her pain was "controlled" with Soma. She complained of some weakness in her legs, but neurological examination was intact and she demonstrated good dorsiflexion on examination. (Exs.11F, 13F).

There is no indication that Dr. Gessner examined Claimant after December 1986. An update of his records as of April 2000 indicated no records after December 1986. (Ex. 13F). Claimant testified that she stopped seeing Dr. Gessner when her worker's compensation claim was settled.

Lumbosacral CT on January 8, 1987 showed no evidence of bulging or herniation. MRI on March 16, 1987 showed degenerative disc changes with minimal bulging at L5-S1. (Ex. 1F).

Claimant was admitted to Chalmette Medical Center from January 23 to 25, 1989 for evaluation low back pain

complaints. She said she had sustained an injury half a year earlier. She complained of a constant dull ache in her low back with radiation down the right lower extremity to the foot. Sensory examination was normal in the lower extremities. Motor examination indicated approximately 4+/5 strength throughout. Lumbar myelogram/CT showed mild bulging of the lower 2 lumbar discs. Surgical treatment was not thought to be indicated. The impression was low back syndrome. (Ex. 2F).

Claimant was evaluated at Chalmette Medical Center on May 28, 1990 for complaints of right hip and shoulder pain after being involved in a motor vehicle accident. X-rays were normal. (Ex. 3F).

There is no evidence to indicate that Claimant sought or received any significant medical treatment for back complaints from January 1989 to January 1994, a period of 5 years.

Claimant was initially examined by Dr. Landry (orthopedist) on January 7, 1994. She reported that she injured her neck in a motor vehicle accident in 1992. She had complaints of intermittent left-sided neck pain and shoulder pain, and intermittent "pins and needles" in the left upper extremity. Examination indicated some tenderness in the left trapezius area. Range of motion was normal in the neck. There was no spasm. Neurological examination of the upper extremities was normal. X-rays of the cervical spine were normal. She also reported a history of "three damaged discs" in her low back, but there was no indication of specific low back complaints or examination of the low back at that time. Cervical MRI on January 13, 1994 was said to show a small disc herniation at C6-7. On March 28, 1994, Claimant complained of left-sided neck pain with intermittent radiation into the left upper extremity. On examination there was no tenderness or spasm. Cervical range of motion was normal except for slight limitation of rotation to the left. There was no indication of neurological abnormality in the upper extremities

except for diffuse weakness on the left. On July 27, 1994, Dr. Landry noted that EMGs/NCS on July 20, 1994 had shown no abnormalities. Claimant was not interested in surgery, and it was noted that she was involved in litigation. (Ex. 4F).

Claimant underwent uterine surgery (D&C) at Washington/St. Tammany Medical Center on March 27, 1996. Her complaints indicated two heavy menstrual periods per month over the previous year. A detailed pre-surgical history and physical indicated that she was well nourished and in no acute distress. Her past medical history indicated nothing about problems with her neck, back, or hands. There was no indication that she considered herself disabled from working. She described her occupation as "housewife". She was said to be taking Pepcid for heartburn. She did not report any pain medication. (Ex. 5F).

Claimant returned to Dr. Landry on May 3, 1996. She complained of neck pain and headaches with intermittent pain, numbness, and tingling in the upper extremities (more on the left). She denied any change over the past two years and said that her symptoms were not bad enough to want surgery. Examination indicated some tenderness in the neck, but no spasm. On that date, Dr. Landry also examined Claimant's back. (During the previous two years of treatment there had apparently been no significant complaints or examination relating to the back). The examination indicated low back tenderness, but no spasm. She was able to flex forward to 60 degrees. Reflex and sensory examinations were normal. The impression was cervical and lumbar disc disease. Soma was prescribed "as needed". (Ex. 4F)

After continuing complaints of irregular menstrual bleeding, Claimant underwent total hysterectomy in May 1996. A detailed pre-surgical history and physical reflects some complaints related to sinus trouble and heartburn. However, there is absolutely no mention of neck, back, or hand problems,

or any indication that she considered herself physically disabled. She again reported her occupation as housewife. (Ex. 5F).

Claimant returned to Dr. Landry on January 17, 1997. Neurovascular examination of the upper extremities was intact. Straight leg raising was said to be positive. (Ex. 4F).

An upper GI series on March 14, 1997 indicated a small sliding hiatal hernia with minimal reflux and active superficial peptic ulcer disease.

Claimant was hospitalized from July 15 to 16, 1997 for evaluation of chest pain. On admission, she reported a recent episode of chest tightness. She reported that she was otherwise generally well (again clearly indicating that she did not consider herself disabled from working). She reported a history "many years ago" of "disc collapse", but her current complaints included only some occasional neck pain and stiffness. She did not report that she was taking any pain medication. She did not complain of problems with her back or hands. Her activities of daily living were said to be "good and normal" (again clearly indicating that she did not consider herself disabled). Examination of the extremities was said to be within normal limits, and neurological examination was entirely intact. EKG showed some abnormalities. She was scheduled for cardiac follow-up to rule out unstable angina (see below). (Ex. 5F).

Claimant returned to Dr. Landry on July 18, 1997. He noted that her litigation had ended. She complained of continuing symptoms, but said that she would gradually increase her activities. (Ex. 4F).

A stress test on August 4, 1997 was negative for cardiac ischemia. (Ex. 6F).

On November 20, 1997, Claimant was seen at Washington/St. Tammany hospital with a rib contusion. At that time, her only medication was said to be Pepcid (no pain medication). (Ex. 5F).

Claimant returned to Dr. Landry on April 22, 1998. She complained that her neck bothered her with "occasional" stiffness and tension headaches. She complained of "constant" low back pain, but said that she could live with it. She complained of "occasional" numbness and tingling in the lower extremities with long sitting. That complaint was said to involve most of the left leg and the right foot. She said that she was trying to walk a mile a day. (Ex. 4F).

At the request of the Administration, Claimant was examined by Dr. Keppel (orthopedic surgeon) on November 2, 1998. Dr. Keppel noted the history of C6-7 disc herniation reflected in Dr. Landry's records. Claimant complained of some discomfort in her neck. There was no evidence of muscle spasm, atrophy, or motor weakness, and her reflexes were intact. Neurological examination was normal except for a complaint of numbness in the entire right hand. Tinel and Phalen signs were positive on the right.

Dr. Keppel thought the right hand complaint might be secondary to carpal syndrome of the right hand and wrist. Claimant complained of low back pain; however, there was "very little in the way of neurologic findings". She had subjective weakness in all motor groups, but Dr. Keppel was not sure if her effort was good. Her gait was normal and she demonstrated forward flexion to 80 degrees. There was no atrophy, and sensory examination was intact. X-rays of the cervical and lumbar spine were essentially negative. Dr. Keppel concluded that Claimant should be able to perform sedentary and light duty activities. (Ex. 7F).

Claimant returned to Dr. Landry on April 26, 1999 for follow-up of "chronic neck and low back pain". She stated that her back had bothered her "a lot" during the previous year because she was lifting her invalid father. Examination indicated lumbar tenderness, but no spasm. Straight leg raising was 90 degrees bilaterally. Examination of the neck indicated

normal curvature, no spasm, and full motion. Examination of the extremities indicated intact and symmetrical reflexes. Despite the clear and apparent lack of positive findings, Dr. Landry stated that Claimant was "disabled from gainful employment".

On October 25, 1999, Claimant was seen by Dr. Landry for follow-up on her neck and back. She complained of increased tingling in the right hand over the previous 6 weeks and right hand weakness with repetitive use. Examination of the hand now indicated negative Tinel's and Phalen's signs. Sensation was said to be diminished in the right middle finger tip. Dr. Landry's impression included cervical and lumbar disc herniation "by history," and he further concluded that she might have carpal tunnel syndrome on the right. (Ex. 12F) L/Clearly, there was not even a definitive diagnosis that Dr. Landry could base on his clinical findings and results of diagnostic studies.

At the request of Claimant's attorney, Dr. Landry completed a form on October 25, 1999. He checked the following items on the form as being present: pain, significant limitation of spinal movement, sensory loss, reduced grip strength bilaterally, numbness and cramping in the right hand with use, low back pain with sitting for protracted periods, and a need to recline periodically for relief of pain. He indicated that the following were not present: muscle spasm, appropriate radicular distribution of significant motor loss with muscle weakness, and reflex loss. He believed that Claimant was able to lift 20 pounds at a time and stand/walk for 2 hours out of an 8 hour day with breaks. He did not believe that she could sit for 6 hours out of an 8 hour day or alternate standing and sitting for 8 hours without walking about or reclining. Claimant's diagnoses were said to/lumbar and C6-7 disc herniation "by history" and possible carpal tunnel syndrome. (Ex. 10F). Again, the impression does indicate any definitive diagnosis.

Dr. Gessner completed the same form provided by

Claimant's attorney. The form was presumably completed shortly before it was received by the Administration on November 8, 1999. By that time, Dr. Gessner had not treated Claimant in nearly 13 years. He indicated that, as of June 30, 1986 (the date she was last insured under the Act), Claimant had the following: bilateral numbness in her hands with any significant use, reduced grip strength bilaterally, "pins and needles" and cramping with writing for more than 10 minutes, low back pain with sitting for protracted periods, and a need to recline periodically on most days to relieve pain. Dr. Gessner indicated that Claimant could lift only 10 pounds at a time and could not sit or stand/walk for even 2 hours out of an 8 hour day. Again, it is to be noted that these symptoms and limitations were merely checked by Dr. Gessner on the form provided by the attorney. The diagnosis was said to be chronic low back pain and cervical disc disease. (Ex. 9F).

On March 24, 2000, Claimant was examined by Dr. Laborde (an associate of Dr. Landry). She complained of neck pain radiating into her right hand with numbness, but said that the pain and numbness had improved. She demonstrated good range of motion in her neck and was neurologically intact. Claimant said that she would obtain x-rays at Charity Hospital (but there is no indication that she did so). (Ex. 12F).

At the hearing, Dr. Weisberg's testimony indicated as follows: The objective medical evidence does not support the diagnoses or degree of limitation set forth by either Dr. Gessner or Dr. Landry. The medical records support a soft tissue musculoskeletal impairment at best. There is no evidence of radiculopathy. There is no evidence of motor disability related to the right carpal tunnel syndrome. There is no significant indication of anemia related to Claimant's history of irregular uterine bleeding. The degree of pain alleged by Claimant is not supported by the clinical findings or objective studies. There is almost nothing in the way of clinical findings noted by either

Dr. Gessner or Dr. Landry, but only Claimant's subjective complaints. The findings reflected in the records of Dr. Gessner and Dr. Landry equate to the same degree of limitation set forth by the consultative orthopedic examiner (Dr. Keppel). Dr. Weisberg agreed with Dr. Keppel that Claimant should be able to perform sedentary and light work.

The medical evidence establishes carpal tunnel syndrome of the dominant right hand. This is a "severe" impairment, but was not diagnosed and is not shown to have caused any significant limitation of work-related functioning prior to 1998 (2 years after the date last insured). Stone v. Heckler, 752 F.2d 1099 (5th Cir. 1985); Social Security Ruling 96-3p.

The evidence does not show any "severe" cervical or lumbar disc herniation. As noted above an MRI in 1987 and CT/myelogram in 1989 showed only mild or minimal bulging at one or two lumbar levels, and an MRI in 1994 showed only a small disc herniation at C6-7. Surgery has not been indicated. Claimant has sought only sporadic and limited conservative treatment. As Dr. Weisberg testified and the treatment records reflect, there have been no significant persistent neurological findings, and all diagnostic studies have shown only mild or no abnormalities (including the negative EMG/NCS of the upper extremities). The weight of the medical evidence shows, at most, a persistent or recurrent "severe" soft tissue disorder of the spine superimposed on the mild degenerative changes. This conclusions is consistent with the testimony of Dr. Weisberg, as supported by the clinical findings of the two treating physicians.

The evidence does not show any "severe" cardiac, gastrointestinal, or reproductive disease. Cardiac testing was negative for ischemia. Claimant is not under follow-up for any cardiac condition. She did not allege any chest pain or other cardiac symptoms at the hearing. The evidence shows a small

hiatal hernia and superficial peptic ulcer disease. The symptoms of these conditions are apparently reasonably well controlled on medication. Claimant has not alleged any work-related functional impairment resulting from her gastrointestinal conditions. At the hearing, Claimant's attorney made a considerable effort to highlight Claimant's allegations concerning her reproductive system. However, when asked directly, the attorney stated that they were not alleging such problems to be a "severe" medically determinable impairment. Claimant alleged that she bled continuously for seven months at a time for two years. However, Dr. Weisberg testified that such bleeding would have meant severe anemia, which is not shown in the record. There is only a brief note in 1995 indicating that she was taking an iron supplement. The medical records indicate that Claimant complained of heavy uterine bleeding occurring twice per month (not quite as bad as she alleged at the hearing), which was resolved with the hysterectomy.

The evidence does not show an impairment or combination of impairments which meets or equals the criteria of any impairment described in Appendix 1, Subpart P, Regulations Part 404.

Claimant testified that, in 1980, she was suffering with back problems such that she was unable to drive. She obtained a GED in 1985. In 1998, she helped care for her invalid father, but denied lifting him. She alleged that she remains unable to work because of problems with her back, neck, hands, and legs. She takes hot showers to relieve muscle spasms. She has been maintained on Soma since 1980. She has "pins and needles" pain in her legs. She now drives very seldom.

Claimant's allegations concerning her symptoms and related functional limitations lack credibility. While her medically determinable conditions can reasonably be expected to produce some symptoms, the weight of the evidence does not

demonstrate persistent symptoms or related functional limitations that would preclude her from performing at least light and sedentary work (with limited use of the right hand since 1998). As discussed above, the objective medical evidence has shown only minor degenerative changes of the cervical and lumbar spine with no significant persistent indications of neurological abnormality on clinical examination. She has been under sporadic conservative care. As noted above, detailed history and physical examinations on three occasions did not indicate any significant back, neck, hand, or leg complaints. Claimant's allegation that she has taken Soma since 1980 is contrary to the medical evidence and reason. As noted above, the medical records indicate several occasions (outside of the records of Dr. Landry and Dr. Gessner) when she reported no pain medication. Moreover, Dr. Weisberg testified that Soma is a short-term medication which loses its effect after 6 to 12 months. The fact that Drs. Gessner and Landry continued to prescribe Soma for extended periods of time calls into question their belief of Claimant's subjective complaints. Neither Dr. Gessner or Dr. Landry indicated that Claimant's symptoms were severe enough to warrant surgery. Claimant has made some admissions of significant daily activities consistent with an ability to perform at least light and sedentary work activity. As noted above, during a detailed history and physical in 1997, she described her daily activities as "good and normal". Contrary to her testimony, the medical records indicate that she did lift her invalid father while caring for him. In a report to the Administration filed with her application, her admitted daily activities included cooking, shopping, visiting friends, and driving. (Ex., 1E/4), While she attempted to portray her abilities in a less favorable light at the hearing, it was apparent that she has engaged in reasonably normal activities during the 20-year period since the alleged onset date. She cared of her mother and father, got a GED, went through pregnancy and childbirth

twice, and raised her children. Her allegation of doing these things only through family help is not persuasive or credible. Social Security Ruling 96-7p.

The evidence establishes that Claimant has had the residual functional capacity to perform light work activities with (since 1998) moderate limitation of the dominant right hand with regard to fine manipulation. The credible evidence does establish any further exertional or non-exertional limitations on her ability to perform work activities. These conclusions are consistent with the weight of the medical evidence, including the opinion of the consultative orthopedic examiner
and the medical expert at the hearing. Dr. Weisberg's conclusions were well supported and consistent with the weight of the other medical evidence, including the minimal clinical findings and diagnostic study results reflected in the treatment records.

The opinions of the two treating physicians (Gessner and Landry) with regard to diagnosis and functional assessment were clearly based on unsubstantiated subjective complaints and are without support. They are not entitled to controlling weight. The opinions set forth by Dr. Gessner in November 1999 (on the form provided by Claimant's attorney) are quite inconsistent and unsubstantiated. His functional restrictions, and particularly his limitation on sitting, clearly contradict his earlier and repeated statement that Claimant could perform "sedentary" secretarial-type work. His statements indicating severe symptoms and very limited functional ability are contrary to his repeated statements that Claimant's complaints did not indicate a need for surgery. His reported diagnosis of "cervical disc disease" and functional limitations related to the upper extremities are not at all reflected in his treatment records. Other than a brief diagnosis of cervical strain, his care was almost exclusively related to Claimant's low back

complaints. Dr. Gessner conclusions of November 1999 were clearly based on subjective complaints, including complaints that Claimant had not yet voiced at the time of his treatment. Dr. Gessner provided medication for subjective symptoms during a period of worker's compensation litigation, and his conclusions are not supported by his clinical findings or objective diagnostic test results. Dr. Landry's treatment records and functional opinions set forth in October 1999 reflect no definitive diagnosis or objective findings. He merely noted the "history" of lumbar and cervical disc herniation and the possibility of carpal tunnel syndrome. Contrary to his indication on the form in October 1999, his records reflect no sensory deficits except for decreased sensation in the right middle finger tip on one occasion. Dr. Landry had no objective findings except for the MRI showing a small cervical disc herniation in 1994. The EMG/NCS and clinical examinations showed no evidence of radiculopathy. Dr. Landry's conclusion that Claimant cannot sustain alternated standing and sitting throughout the course of an 8 hour day is utterly without support. Like Dr. Gessner, Dr. Landry treated Claimant for subjective symptoms which, at least for some period of time, were related to litigation. Like Dr. Gessner, Dr. Landry did not think that surgery was indicated. Social Security Rulings 96-2p and 96-6p.

The evidence does not indicate any past relevant work or work skills. The burden of proof thus shifts to the Administration to show jobs existing in significant numbers in the national economy that he can perform.

Claimant was able to perform a full range of light work prior to the onset of right-sided carpal tunnel syndrome in 1998. Therefore, rule 202.20 of the Medical-Vocational Guidelines (Appendix 2, Subpart P, Regulations Pt. 404) directs a finding that she was "not disabled". Since 1998, Claimant's non-exertional limitation with regard to the use of her right

hand, requires that rule 202.20 be used only as a framework. Vocational expert testimony was obtained to determine whether jobs exist in significant numbers within the parameters of Claimant's residual functional capacity and other vocational factors.

The vocational expert was asked whether an individual of the same age, education, and past work experience as Claimant, with the residual functional capacity to perform work as set forth above, could perform any jobs existing in the national economy. The vocational expert testified that such a person would be precluded from performing production-type work. However, they would be able perform several office jobs, including mail clerk, file clerk, information clerk, receptionist, telephone solicitor, and order clerk. The number of such jobs available in the sedentary category would be in excess of 100,000 in Louisiana and in the millions nationwide. The number of such jobs in the light category would be between 200,000 and 400,000 in Louisiana. With regard to the number of such jobs available in 1986 (at the date Claimant was last insured), the vocational expert testified that the above numbers would be reduced by 15 to 20 percent.

The vocational expert's testimony was credible and indicative of jobs existing in significant numbers that Claimant can perform and was able to perform when she was last insured under the Act.

As the evidence establishes that Claimant is capable of performing jobs existing in significant numbers in the national economy, she is "not disabled within the meaning of the Social Security Act and corresponding regulations.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. Records from the Administration indicate that Claimant met the insured status requirements of the Act on the date she allegedly became unable to work, September 19, 1980, and that she continued to meet them only through June 30, 1986.

2. There is no evidence of substantial gainful activity since the alleged onset date.

3. Claimant has the following "severe" impairments: carpal tunnel syndrome of the right upper extremity (since 1998) and soft tissue impairments superimposed on mild degenerative changes in the cervical and lumbar spine.

4. The evidence does not establish an impairment or combination of impairments which meets or equals the criteria of any impairment described in Appendix 1, Subpart P, Regulations Part 404.

5. Claimant's allegations concerning her symptoms and limitations lack credibility.

6. Claimant has the residual functional capacity to perform light and sedentary work with (since 1998) moderate limitation of the dominant right hand for fine manipulation.

7. Claimant does not have any past relevant work.

8. Claimant is 44 years old (and was 30 at the date she was last insured under the Act). She has a GED, no work experience in the past 15 years, and no transferable work skills.

9. Considering her age, education, past work experience, and residual functional capacity, there are jobs existing in significant numbers in the national economy that Claimant is capable of performing and has been capable of performing since her alleged onset date. Examples of such jobs include mail clerk, file clerk, information clerk, receptionist, telephone solicitor, and order clerk.

DECISION

It is the decision of the Administrative Law Judge, based on the applications for disability insurance benefits and

supplemental security income protectively filed as of July 22, 1998, that Claimant is "not disabled" within the meaning of the Social Security Act and corresponding regulations.

S/MICHAEL S. HERTZIG
Administrative Law Judge

SEP 2 5 2000

APPENDIX B:

ACTION OF APPEALS COUNCIL
ON REQUEST FOR REVIEW

Ms. Maxann C. Fink
335 Fox Croft St
Slidell, LA 70461

Dear Ms. Fink:

The Appeals Council has considered the request for review of the Administrative Law Judge's decision issued on September 25, 2000.

Social Security Administration regulations provide that the Appeals Council will grant a request for review where: (1) there appears to be an abuse of discretion by the Administrative Law Judge; (2) there is an error of law; (3) the Administrative Law Judge's action, findings, or conclusions are not supported by substantial evidence; or (4) there is a broad policy or procedural issue which may affect the general public interest. The regulations also provide that where new and material evidence is submitted with the request for review, the entire record will be evaluated and review will be granted where the Appeals Council finds that the Administrative Law Judge's

actions, findings, or conclusion is contrary to the weight of the evidence currently of record (20 C.F.R. 404.970 and 416.1470).

The Appeals Council has concluded that there is no basis under the above regulations for granting your request for review. Accordingly, your request is denied and the Administrative Law Judge's decision stands as the final decision of the Commissioner of Social Security in your case. In reaching this conclusion, the Appeals Council has considered the applicable statutes, regulations, and rulings in effect as of the date of this action.

Specifically, the Appeals Council considered the final regulations, effective February 19, 2002, implementing the new lisitngs for musculoskeletal (and related) impairments. The new regulations do not provide a basis to change the Administrative Law Judge's decision.

If you desire a court review of the Administrative Law Judge's decision, you may commence a civil action by filing a complaint in the United States District Court for the judicial district in which you reside within sixty (60) days from the date of the
receipt of this letter. It will be presumed that this letter is received within five (5) days after the date shown above unless a reasonable showing to the contrary is made. The complaint date should name the Commissioner of Social Security as the defendant and should include the Social Security number(s) shown at the top of this notice. The right to court review is provided for in sections 205(g) and 1631(c)(3) of the Social Security Act, as amended (42 U.S.C. 405(g) and 1388(c)(3)).

If you cannot file your complaint within 60 days, you may ask the Appeals Council to extend the time in which you may begin

a civil action. However, the Council will only extend the time if you provide a good reason for not meeting the deadline. Your reason(s) must be set forth clearly in your request.

If a civil action is commenced, the Commissioner must be served by sending a copy of the summons and complaint by registered or certified mail to the General Council, Social Security Administration, Room 611, Altmeyer Building, 6401 Security Boulevard, Baltimore, MD 21235. (See rules 4(c) and (i) of the Federal Rules of Civil Procedure.) In addition, you must serve the United States Attorney for the district in which you file your complaint and the Attorney General of the United States, as provided in the Federal Rules of Civil Procedure.

Sincerely yours,

S/ C. Michael Sullivan
Acting Administrative Law Judge

APPENDIX C:

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

MAXANN C. FINK	CIVIL ACTION
VERSUS	NO: 02-2136
JO ANNE B. BARNHART,	SECTION: "B"(1)
COMM. SOCIAL SECURITY ADMINISTRATION	

MAGISTRATE'S REPORT AND RECOMMENDATION

Plaintiff, Maxann C. Fink ("Fink"), seeks judicial review, pursuant to Section 405(g) of the Social Security Act (the "Act"), of the final decision of the Commissioner of the Social Security Administration (the "Commissioner") denying her claims for disability insurance benefits under Title II of the Social Security Act ("Act"), 42 U.S.C. § 423, and for supplemental security income ("SSI") under Title XVI of the Act, 42 U.S.C. § 1382(a)(3). This matter is before the court on the parties' cross-motions for summary judgment, as ordered by the court's minute entry of February 24, 2003 (Rec. doc. 14).

PROCEDURAL HISTORY

On August 11, 1998, Fink submitted an application for benefits based on an inability to work since September 10, 1980. R. 106-08. Her disabling conditions were described as five ruptured disks, three in the back and two in the neck. R. 125. She reported receipt of workers' compensation benefits from September 9, 1981 through September, 1987 and a lump sum payment of $65,261.00 in May, 1991 with $7,940 used for medical expenses and $7,526 for attorney's fees. R. 109. These were related to a September 9, 1980 injury to her back when she

was employed as a selector earning $269.20 per week. R. 112-20.

In September and October, 1998, the Commissioner sought and received medical records from Chalmette Delaronde Medical Center, Washington St. Tammany Regional Medical Center ("Bogalusa Charity") and Dr. Edmund Landry. R. 77, 153, 156 and 166. On November 12, 1998, a consultative examination report from Dr. Frederick L. Keppel, an orthopedic surgeon, was received. R. 77 and 216-17.

On November 23, 1998, Fink was notified that her claim for benefits was denied. R. 77-84. Her request for reconsideration was denied on March 9, 1999. R. 85-90. The deadline for Fink to request a hearing before an AU was May 12, 1999. R. 91.

On November 1, 1999, the Commissioner received from Fink a questionnaire completed by Dr. Landry on October 25, 1999. R. 221-22. On November 8, 1999, the Commissioner received from Fink an undated questionnaire completed by Dr. Ralph Gessner. R. 219-20. On November 9, 1999, attorneys Brian Spurlock and Robert Moffett were appointed as Fink's representatives. R. 24.[1]

On December 14, 1999, Fink requested a hearing before an ALJ. R. 94. She explained that she missed the May 12, 1999 deadline because from August 26, 1998 until his death on April 6, 1999, she cared for her father, a stroke victim. R. 92-93. A statement submitted by Fink reported that since her application her right hand and arm hurt and were weak. R. 137. She also reported that she was seeing Dr. Landry every six months for prescriptions. R. 137.

On March 1, 2000, Fink notified the Commissioner that she would submit additional medical evidence as soon as it was

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[1]Up to this point in the administrative process Fink was unrepresented.

received by her. R. 140. On April 3, 2000, she submitted records from Dr. Gessner for the period from September 10, 1980 through December 16, 1986. R. 223-33 and 238-46. On May 1, 2000, she submitted records from Dr. Landry for the period from April 26, 1999 through March 24, 2000. R. 234-37.

On July 8, 2000, the ALJ notified the vocational expert and Leon Weisberg, M.D. of the need for their testimony at the hearing. R. 101-04. Dr. Weisberg was sent copies of the pertinent medical exhibits. R. 103. On July 26, 2000, there was a hearing before the ALJ where the following testified: (1) Fink; (2) Dr. Weisberg; and (3) Thomas Merinier, a vocational expert. R. 25. On September 25, 2000, a decision denying Fink's claim for benefits was issued. R. 11-23.

On November 9, 2000, Fink notified the Appeals Council that her appeal was based in part on the Commissioner's failure to comply with 20 C.F.R. §404.1512(e)(l).[2] She requested that she be provided with evidence of attempts by the Commissioner to have consultative examinations performed by treating physicians. Rec. doc. 10. On June 7, 2002, the Appeals Council denied her request for review of the ALJ's decision. R. 5-6.

Fink filed her appeal with this court on July 12, 2002. Rec. doc. 1. The case was submitted on cross-motions for summary judgment on February 24, 2003. Rec. doe. 14. On March 18, 2003, Fink filed a memorandum in response to the Commissioner's cross-motion for summary judgment. Rec. doc. 16. Fink is represented by counsel in this proceeding.

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[2]404 C.F.R. § 404.1512(e)(1) pertains to the circumstances under which the Commissioner will recontact a claimant's treating physician.

STATEMENT OF ISSUES ON APPEAL

Plaintiff's request for judicial review raises the following issues:

a. Did the Commissioner err by failing to recontact the treating physicians before ordering a consultative examination?

b. Did the Commissioner err by ordering a consultive examination without soliciting a treating physician to perform the examination?

c. Did the Commissioner err by providing the consultative examination report to the medical expert that testified at the hearing before the ALI without recontacting the treating physician?

d. Did the ALJ err by rejecting the findings of the treating physicians without attempting to recontact them?

e. Did the ALJ err by rejecting the findings of the treating physician without applying the criteria found in 20 C.F.R. § 404.1527(d)(2).

THE ALJ' S FINDINGS RELEVANT TO ISSUES ON APPEAL

The ALJ made the following findings relevant to the issues on appeal:

1. Records from the Administration indicate that Claimant met the insured status requirements of the Act on the date she allegedly became unable to work, September 19, 1980, and that she continued to meet them only through June 30, 1986.

2. There is no evidence of substantial gainful activity since the alleged onset date.

3. Claimant has the following "severe" impairments: carpal tunnel syndrome of the right upper extremity (since 1988) and soft tissue impairments superimposed on mild degenerative changes in the cervical and lumbar spine.

4. The evidence does not establish an impairment or combination of impairments which meets or equals the criteria of any impairment described in Appendix 1, Subpart P, Regulations Part 404.
5. Claimant's allegations concerning her symptoms and limitations lack credibility.
6. Claimant has the residual functional capacity to perform light and sedentary work with (since 1998) moderate limitation of the dominant right hand for fine manipulation.
7 Claimant does not have any past relevant work.
8. Claimant is 44 years old (and was 30 at the date she was last insured under the Act). She has a GED, no work experience in the past 15 years, and no transferable work skills.
9. Considering her age, education, past work experience, and residual functional capacity, there are jobs existing in significant numbers in the national economy that Claimant is capable of performing and has been capable of performing since her alleged onset date.. Examples-of such jobs include mail clerk, file clerk, information clerk, receptionist, telephone solicitor, and order clerk. R. 22-23.

ANALYSIS

a. Standard of Review.

The function of this court on judicial review is limited to determining whether there is substantial evidence in the record to support the final decision of the Commissioner as trier of fact and whether the Commissioner applied the appropriate legal standards in evaluating the evidence. *Newton v. Apfel*, 209 F.3d 448, 452 (5`h Cir. 2000); *Spellman v. Shalala*, 1 F.3d 357, 360 (5th Cir. 1993). Substantial evidence is more than a scintilla but less than a preponderance and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Richardson v. Perales*, 402 U.S. 389, 401,

91 S.Ct. 1420, 1427 (1971); *Newton*, 209 F.3d at 452. Alternatively, substantial evidence may be described as that quantum of relevant evidence that a reasonable mind might accept as adequate to support a conclusion. *Carey v. Apfel*, 230 F.3d 131, 135 (5`h Cir. 2000). This court may not re-weigh the evidence, try the issues de novo or substitute its judgment for the Commissioner's. Id.; *Selders v. Sullivan*, 914 F.2d 614, 617 (5th Cir. 1990).

The ALJ is entitled to make any finding that is supported by substantial evidence, regardless of whether other conclusions are also permissible. See *Arkansas v. Oklahoma*, 503 U.S. 91, 113, 112 S.Ct. 1046, 1060 (1992). Despite this court's limited function, it must scrutinize the record in its entirety to determine the reasonableness of the decision reached and whether substantial evidence exists to support it. *Villa*, 895 F.2d at 1022; *Johnson v. Bowen*, 864 F.2d 340, 343-44 (5th Cir. 1988). Any findings of fact by the Commissioner that are supported by substantial evidence are conclusive. *Ripley v. Chater*, 67 F.3d 552, 555 (5th Cir. 1995).

To be considered disabled and eligible for SSI, plaintiff must show that he is unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § § 423(d)(1)(A), 13 82c(a)(3)(A). The Commissioner has promulgated regulations that provide procedures for evaluating a claim and determining disability. 20 C.F.R. §§ 404.1501 to 404.1599 & appendices, §§ 416.901 to 416.-998 (1997). The regulations include a five-step evaluation process for determining whether an impairment prevents a person from engaging in any substantial gainful activity. Id. §§ 404.1520, 416.920; *Newton v. Apfel*, 209 F.3d at 453; *Greenspan v.*

Shalala[3], 38 F.3d 232, 236 (5th Cir. 1994), cert. den. 115 S. Ct. 1984 (1995). The five-step inquiry terminates if the Commissioner finds at any step that the claimant is or is not disabled. *Leggett v. Chater*, 67 F.3d 558, 564 (5th Cir., 1995).

The claimant has the burden of proof under the first four parts of the inquiry. *Id.* If he successfully carries this burden,

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[3]The five-step analysis requires consideration of the following:

First, if the claimant is currently engaged in substantial gainful employment, he or she is found not disabled. 20 C.F.R. §§ 404.1520(b), 416.920(b).

Second, if it is determined that, although the claimant is not engaged in substantial employment, he or she has no severe mental or physical impairment which would limit the ability to perform basic work-related functions, the claimant is found not disabled. Id. §§ 404.1520(c), 416.920(c).

Third, if an individual's impairment has lasted or can be expected to last for a continuous period of twelve months and is either included in a list of serious impairments in the regulations or is medically equivalent to a listed impairment, he or she is considered disabled without consideration of vocational evidence. Id. §§ 404.1520(d), 416.920(d).

Fourth, if a determination of disabled or not disabled cannot be made by these steps and the claimant has a severe impairment, the claimant's residual functional capacity and its effect on the claimant's past relevant work are evaluated. If the impairment does not prohibit the claimant from returning to his or her former employment, the claimant is not disabled. Id. §§ 404.1520(e), 416.920(e).

Fifth, if it is determined that the claimant cannot return to his or her former employment, then the claimant's age, education and work experience are considered to see whether he or she can meet the physical and mental demands of a significant number of jobs in the national economy. If the claimant cannot meet the demands, he or she will be found disabled. Id. §§ 404.1520(f)(1), 416.920(f)(1). To assist the Commissioner at this stage, the regulations provide certain tables that reflect major functional and vocational patterns. When the findings made with respect to claimant's vocational factors and residual functional capacity coincide, the rules direct a determination of disabled or not disabled. *Id.* § 404, Sub-pt. P, App. 2, §§ 200.00-204.00, 416.969 (1994) ("Medical-Vocational Guidelines").

the burden shifts to the Commissioner to show that other substantial gainful employment is available in the national economy, which the claimant is capable of performing. *Greenspan*, 38 F.3d at 236; *Kraemer v. Sullivan*, 885 F.2d 206, 208 (5th Cir. 1989). When the Commissioner shows that the claimant is capable of engaging in alternative employment, "the ultimate burden of persuasion shifts back to the claimant." *Id.*; accord *Selders*, 914 F.2d at 618.

The Court "weigh[s] four elements of proof when determining whether there is substantial evidence of disability: (1) objective medical facts; (2) diagnoses and opinions of treating and examining physicians; (3) the claimant's subjective evidence of pain and disability; and (4) [her] age, education, and work history." *Martinez v. Chater*, 64 F.3d 172, 174 (5th Cir. 1995). 'The Commissioner, rather than the courts, must resolve conflicts in the evidence." *Id.*

b. Testimony of Maxann Fink and vocational expert at hearing before ALJ.

Fink completed the eleventh grade and obtained a GED. R. 33. She did not work after 1982. R. 34. She received workers' compensation benefits for eleven years after her injury and was under Dr. Gessner's care during that time. R. 35. Fink was sent to a physical therapist by Dr. Gessner. R. 37. After her workers' compensation claim was settled, she went to Bogalusa Charity Hospital. R. 35.

Fink had three children and their ages at the time of the hearing were 21, 18 and 4. R. 38-39. She was required to rest in bed during her pregnancies and during one of them she was hospitalized for a month and a half. R. 41-43. She kept up with her children's activities and teachers at school but she was not active in PTA groups or classroom activities. R. 45-46 and 49. Fink attributed the eighteen year delay in filing her claim to a divorce, personal things and procrastination. R. 37-38. She was unable to work because of her back, neck, hands and legs. R.

44. Fink took Soma, a pain killer, -four times a day for eighteen years. R. 39. She rarely drove a car because her hands became numb. R. 46-47. She took hot showers in the morning to relieve her muscle spasms. R. 47. Her family and friends shopped for her. R. 45. She rarely went to the grocery store. R. 45. Fink took care of her invalid father in 1997 and 1998. R. 49. She never lifted her father because there was special equipment for that purpose. R. 50. It was only necessary for her to crank the equipment and pull it. R. 51.

The vocational expert testified that there were jobs available for a younger individual with a GED and no work experience who had a moderate impairment of the dominant right upper extremity and could occasionally engage in fine manipulation with the right hand but could otherwise engage in a full range of sedentary work activities . R. 70. A light impairment would increase the number of jobs available. R. 71. If the limitations described by Fink were added, there would be no jobs available. R. 73.

c. Medical evidence including the testimony of Dr. Leon Weisberg presented at the hearing.

On January 9, 1981, Fink was seen by Dr. Gessner.[4] She reported that on September 10, 1980, she hurt her back while lifting a case of bottles above her head. R. 224. She indicated there were no prior injuries to her back. The diagnosis was a slight degree of spondylolisthesis at L5-S1 and spina bifida.[5] R. 224. On February 18, 1981, Fink reported to Dr. Gessner that she was pregnant. Fink was seen by Dr. Gessner twice in May, 1981. R. 226.

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[4]Dr. Gessner's speciality is not identified in the medical records

[5] Disorder of the spinal nerve roots. Stedman's Medical Dictionary (26th Ed. 1995), p. 1484.

Fink returned to Dr. Gessner in April, 1982. R. 226. A lumbar CT scan was scheduled in June, 1982. R. 226. Fink returned to Dr. Gessner in August, September, October and November, 1982. R. 225-27. Soma was prescribed. R. 225 and 227.

On February 1, 1983, Fink was seen by Dr. Gessner and reported that she continued to have intermittent low back pain especially with physical exertion. Dr. Gessner recommended conservative treatment. He did not believe she could return to her prior work of transferring cases and materials but believed she could possibly do sedentary work. He recommended that she go into a rehabilitation school. Her prescription for Soma was refilled. R. 227. On March 15, 1983, Dr. Gessner reported that Fink had a considerable amount of discomfort in her low back and diagnosed her with a herniated disc at L5-S1 and slight degree of spondylothesis in that area. R. 228. In April, 1983, Dr. Gessner reported that Fink was a candidate for sedentary work and that her pain was controlled with Soma. R. 228. A month later she had more weakness in her left leg but was neurologically intact. R. 228. In July, 1983, she reported numbness in both legs and a mild spasm. R. 228. On August 24, 1983, Dr. Gessner reported that a disc space injection was not appropriate. Fink still had a mild degree of spasm in her back with pain radiating into her right leg. R. 228. In December, 1983, Dr. Gessner reported that she had anxiety about surgery. Soma helped her and Valium was prescribed as a muscle relaxer. R. 228.

In 1984, Fink was seen by Dr. Gessner about once a month. R. 229-30. She continued to report back pain with muscle spasms. She was given a course of physiotherapy but there was only a minimal response. In the first part of the year Soma was prescribed. By June, 1984, Dr. Gessner recommended that she take the Soma only when she was symptomatic. R. 229. On July 24, 1984, he reported that she

still had discomfort but was not to the point where surgery was indicated. R. 230. On November 14, 1984, Dr. Gessner visited with Fink and her rehabilitation counselor. A recent episode of cold weather exacerbated her pain. She had a mild degree of spasm. Dr. Gessner did not feel that Fink was capable of working at that time but that possibly after the first of the year she could return to light duty work. R. 230.

On January 16, 1985, Fink's condition was unchanged. On January 29, 1995, she reported she was in the hospital for nausea and vomiting and was seven weeks pregnant. On March 6, 1985, Dr. Gessner reported that therapy seemed to help her pain. He did not prescribe any medication. R. 231. On May 7, 1985, he reported that she may have problems in her third trimester. He remarked that she was disabled from work activity secondary to her low back injury. R. 231. The baby was born in September, 1985. She reported back pain in November, 1985, and Soma was prescribed. R. 232. Her medication was refilled in December, 1985. R. 232.

From January through August, 1986, Fink was seen by Dr. Gessner at least once a month. Soma and Valium were prescribed. R. 232-33. On May 14, 1986, he reported that she had three children and was trying to keep up with them. She was trying to control her pain by restricting her activities and taking Soma. She was to call him if she had acute pain. R. 233.

On June 25, 1986, Dr. Gessner reported that Fink was involved in a motor vehicle accident the day before. She complained of pain in her neck, right arm, shoulder and leg. Soma and Tylenol #3 were prescribed. R. 233. On July 8, 1986, he reported that Fink was improved. R. 233. Her medications were continued in July. In August, 1986, the Tylenol #3 was eliminated but she was continued on Soma. R. 233. She was seen by Dr. Gessner on November 4, 1986 and on December 16, 1986. R. 233. Dr. Gessner reported that Fink's pain was controlled with Soma 350. She had weakness in her legs. She

was neurologically intact with no sensory loss. He recommended conservative treatment and asked her to return in thee months. Her prescription for Soma was refilled. R. 233.

On January 8, 1987, there was a CT scan of the lumbrosacral spine and there was no evidence of disc bulging or herniation. R. 148. On March 16, 1987, there was a MRI scan of Fink's lumbar spine at Chalmette General Hospital ("Chalmette General"). The study was ordered by Dr. Gessner. The study revealed degenerative disc changes with minimal bulging at L5-S1. R. 147.

On January 23, 1989, Fink was admitted to Chalmette General at the request of Dr. Gessner. R. 149. She reported a constant dull ache in her lower back that radiated down her right leg to her foot. She stated there were intermittent episodes of sharp shooting pain and occasional numbness in her right foot. Her medications were Soma and Darvocet. The diagnosis was low back syndrome. R. 150. A lumbar myelogram and CT scan revealed mild to moderate diffuse bulging at the L4-5 and L5-S1. There was no evidence of disc herniation, stenosis or encroachment on the neural foramina. There were no findings at L3-4. R. 152. Dr. Gessner concluded that surgery was not warranted. Fink was discharged to be treated as an outpatient on a conservative basis. R. 151.

On May 28, 1990, Fink was seen at Chalmette General's emergency room. Drs. Gessner and West were reflected as the admitting and attending physicians. Fink reported she was injured in a motor vehicle accident and complained of pain in the left pelvic and hip area. R. 154. An x-ray failed to find an acute fracture or dislocation. R. 155.

On January 7, 1994, Dr. Landry, an orthopedic surgeon, reported to Michael Lash, an attorney, that he interviewed and examined Fink on January 7, 1994. R. 164. She reported an injury to her neck in a December 16, 1992 accident when she was rear-ended by an eighteen wheeler truck. R. 164. She went

to Slidell Memorial following the accident due to soreness all over and a particularly painful left shoulder. She was given an injection and went to Dr. Raoul Reyes, who treated her with medication and heat therapy three times a week. She stopped seeing Dr. Reyes in June or July, 1993. She was then seen by Dr. Diamond, her family physician.

Dr. Landry reported that Fink complained of intermittent left sided neck and shoulder pain that became worse with weather changes. She described her lower back injury from 1980 and reported that she still had back problems but they were not changed by the December, 1992 accident. She reported taking Motrin when needed and that Soma provided some relief. She also used Tylenol at times. R. 164.

Dr. Landry found that her cervical lordosis was normal. There was tenderness of the left neck muscle and tendon. Her neck motion was normal and without any spasms. The neurological examination of the upper extremities was normal. There was no muscle atrophy. R. 165. Cervical x-rays did not reveal any evidence of fracture, dislocation or demineralization. The disc spaces were normal. R. 165. A cervical MRI revealed a small type Ha disc herniation at C6-7. Dr. Landry recommended cervical traction. R. 163. By March 28, 1994 the cervical traction was discontinued as it only increased her neck pain and caused headaches. R. 162. An EMG and nerve conduction studies done on July 24, 1994 did not reveal any abnormalities. R. 161. Dr. Landry discussed with her the possibility of an anterior cervical fusion at C6-7. She preferred to live with the problem and take Soma, Advil and Tylenol as needed. R. 161. Dr. Landry advised her to settle her litigation as though the surgery would be done so she could proceed with surgery in the future. He recommended that she see him every six months as long as she took prescription medication. R. 161.

On March 14, 1996, Fink was seen at Bogalusa Charity Hospital for complaints of heavy bleeding. R. 211. The

diagnosis was dysfunctional uterine bleeding and dilation and curettage of the uterus was recommended. R. 206 and 209. The physical exam found there was no acute distress. R. 208. The dilation and curettage procedure was completed on March 27, 1996. R. 207. On March 31, 1996, she complained of low abdominal pain. R. 205. On April 1, 1996, bed rest was prescribed. R. 204. On April 8, 1996, no blood was reported. R. 203. On April 15, 1996, there was bleeding and she was scheduled for a total abdominal hysterectomy. R. 202.

Fink returned to Dr. Landry on May 3, 1996 and reported continued problems with neck pain, tension and headaches. R. 160. She did not want surgery but reported intermittent pain, numbness and tingling in the upper extremities, the left more than the right. She also reported back pain. She took Soma four times a day. Dr. Landry examined her neck and back. His diagnosis was cervical and lumbar disc disease. R. 160.

A total abdominal hysterectomy was performed at Bogalusa Charity Hospital on May 8, 1996. R. 197-99. On May 29 and July 1, 1996, Fink was seen at Bogalusa Charity Hospital for post-surgical followup. R. 183-84.

On January 17, 1997, Fink returned to Dr. Landry and reported chronic neck and back pain. R. 158. The diagnosis was cervical and lumbar disc disease. R. 158.

On February 27, 1997, Fink was seen at Bogalusa Charity Hospital for complaints of severe heartburn. She took Pepcid daily and was diagnosed with a possible peptic ulcer. R. 181. On March 14, 1997, Fink was given an upper GI series at Bogalusa Charity. It revealed a small hiatal hernia and active superficial peptic ulcer disease. R. 173. On March 25 and May 1, 1997, she was seen at Bogalusa Charity. R. 178-79.

On June 18, 1997, Fink returned to Dr. Landry and reported that her ligation was over. She complained of chronic neck and back pain with occasional upper extremity radiation.

Her symptoms increased with activity. She took Soma, Pepcid and Ibuprofen. Dr. Landry reported she was to gradually increase her activities with a walking program. R. 159.

On July 15, 1997, Fink was hospitalized for one day at Bogalusa Charity with a complaint of chest pain. R. 177 and 187. At her discharge her condition was stable. Pepcid was prescribed. R. 186. The physical exam did not contain any report of neck or back pain. R. 189-90. On August 4, 1997, a stress test was negative for ischemia. R. 212-15. On November 20, 1997, Fink was seen at Bogalusa Charity following a fall and was diagnosed with a rib contusion. R. 172.- An x-ray indicated a questionable fracture of the end of the eighth rib. R. 171.

On April 22, 1998, Fink returned to Dr. Landry. She was taking Soma and occasionally Tylenol. She complained of occasional stiffness, muscle tension, headaches and constant low back pain of variable intensity. She experienced occasional numbness and tingling in the lower extremities with long sitting. She was walking one mile per day and swam in the summer. R. 157. On May 27, 1998, Fink went to Bogalusa Charity and reported that she had pulled a muscle in her upper back. R. 185.

On November 2, 1998, Fink was seen by Dr. Frederick Keppel, an orthopedic surgeon, at the request of the Disability Determination Services. R. 216. Dr. Keppel found that she should be able to perform sedentary and light duty activities. R. 216-17. His diagnosis and prognosis stated:

> The patient has a history of chronic neck pain, possibly a C6-C7 disc herniation from history, although she shows no signs of any neurologic deficits. Her findings of right hand numbness may be secondary to carpal tunnel syndrome of the right hand and wrist. She also has chronic lower back pain with very little in the way of neurologic findings. The patient showed some

subjective weakness in all motor groups. I am not sure whether or not she is giving a good effort on motor examination.
R. 217.

On April 26, 1999, Fink returned to Dr. Landry, who stated: "The patient says that her neck is about the same. Her back bothered her a lot in the last year as she was lifting her invalid father until he died last month." R. 237. Dr. Landry recommended a liver function study because of her usage of Tylenol and Soma. He felt she was disabled from gainful employment and she was unable to perform activities on regular basis including climbing, bending, lifting and prolonged sitting, standing or walking. R. 237.

On October 25, 1999, Fink returned to Dr. Landry and reported increased tingling in the right hand and weakness with repetitive use. There was diminished sensation in the right middle finger tip. The grip strength for both hands was less than expected as normal. Dr. Landry reported that she remained disabled from employment. R. 236. At that time, he completed a questionnaire indicating that Fink had pain, significant limitation of spinal movement and sensory loss. The answers also indicated she had reduced grip strength bilaterally, felt cramping if she attempted to write for more than about ten minutes, suffered with low back pain after sitting for a protracted period and needed to recline at will periodically during the day for relief of pain. Fink could lift twenty pounds at a time and remain standing or walking for two hours in an eight hour day. She could not stand, walk or sit for six hours in an eight hour day. R. 221. She could not alternate standing or sitting for eight hours without walking about or reclining. R. 222.

On November 8, 1999, Dr. Gessner completed a similar questionnaire with similar results for Fink's condition as of June 30, 1986. R. 219-20.

On March 24, 2000, Fink was seen by Dr. Monroe Laborde, who took over from Dr. Landry. Fink reported pain in her neck that radiated to the right hand with some numbness. She reported improvement in the arm pain and numbness. The examination of her neck revealed a good range of motion and her neurologic status was intact. Dr. Laborde reported that as far as he knew she remained disabled. R. 235.

At the hearing, Dr. Leon Weisberg testified as a medical expert. Dr. Weisberg was board certified in neurology and psychiatry and the chair of those departments at Tulane University Medical Center. R. 51-52. Prior to the hearing Dr. Weisberg reviewed Fink's medical records. He stated that he did not see any severe impairments. R. 53. Spina bifida and spondylolisthesis were radiological diagnoses. The latter indicated anterior displacement of the arterial body. Neither diagnosis caused muscular, skeletal or neurological disturbances. R. 53-54. He testified that a disc herniation by itself did not cause symptoms. R. 54. However, he did not doubt Fink's report of low back or neck pain. R. 54. There was no evidence of radiculopathy (nerve root compression) or mylopathy (spinal cord compression). The reports of muscle spasms were evidence of a soft tissue injury. It was his opinion that Fink had a soft tissue injury unaccompanied by radiculopathy. R. 55. Dr. Weisberg testified that there was evidence of a right sided carpal tunnel syndrome. R. 55. There was no evidence of motor dysfunction of the right hand. With repetitive right hand activity Fink would develop tingling, numbness and weakness in her hand. This would produce some limitations that could be expected to last more than twelve months. R. 55-56.

Dr. Weisberg agreed with the ALJ that there was very little in the record by way of neurologic findings, except for the right hand. R. 57. He testified that Soma was a muscle relaxer and a short term medication and that it was very unusual for a

person to be taking it as long Fink took it. After six months to a year, its effectiveness wore off. R. 58.

Dr. Weisberg agreed that Dr. Landry's report of April 22, 1998 that Fink was walking a mile per day and swimming in the summer (R. 157) was commensurate with Dr. Keppel's finding that she was able to engage in sedentary or light duty (R. 216-17). R. 59. Dr. Weisberg found no support in the medical record for the limitations that Dr. Landry and Dr. Gessner indicated were present when they completed the questionnaires in the fall of 1999. R. 59-61 and 67.

The disc herniation at C6-7 revealed by the January 13, 1994 cervical MRI (R. 163) was a mechanical abnormality. There was no abnormality on the lumbar myelogram done in the late 19-80's (R. 152). R. 58. Dr. Weisberg testified that Fink's statements of limiting pain was not supported by findings on examination by her physicians. He stated that, "[w]hen pain is not supported by findings on examination then it tends to be less severe than when it is supported by findings on examination." R. 68.[6]

d. Plaintiff's Appeal.

Issue No. 1. Did the Commissioner err by failing to recontact the treating physicians before ordering a consultative examination?

Issue No. 2. Did the Commissioner err by ordering a consultive examination without soliciting a treating physician to perform the examination?

Issue No. 3. Did the Commissioner err by providing the consultative examination report to the medical expert that testified at the hearing without

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[6]As to the gynecological issues, Dr. Weisberg did not see a laboratory study in the record to support the diagnosis of anemia. R. 61 and 63-64. Fink's counsel acknowledged that she was not claiming disability on the basis of iron deficiency anemia. R. 66.

recontacting the treating physician?

Issue No. 4. Did the ALJ err by rejecting the findings of the treating physicians without attempting to recontact them?

Finks' first four alleged errors are procedural and related. Rec. doc. 16 at p. 1. In *Morris v. Bowen*, 864 F.2d 333 (5'h Cir. 1988), the Fifth Circuit stated:

> The duty of an appellate court when reviewing an agency decision regarding disability benefits and supplemental security income benefits is not to reweigh the evidence, but merely to determine if there is substantial evidence in the record to support the agency's decision. Moreover, procedural perfection in administrative proceedings is not required. This court will not vacate a judgment unless the substantial rights of a party have been affected. The procedural improprieties alleged by Morris will therefore constitute a basis for remand only if such improprieties would cast into doubt the existence of substantial evidence to support the ALJ's decision. Id. at 335 (citations, brackets and quotation marks omitted). See also *Ferguson v. Barnhart*, 2003 WL 21277130, *1 (E.D.La.)(Duval, J.).

Fink urges that a consultative examination was ordered by the Commissioner without first attempting to recontact the treating physician in violation of 20 C.F.R. § 404.1512(e)(1). This regulation arises in the context of the claimant's burden to establish a disabling impairment.

> [Y]ou have to prove to us that you are blind or disabled. Therefore, you must bring to our attention everything that shows that you are blind or disabled. This means that you must furnish medical and other evidence that we can use to reach conclusions about your medical impairment... .

20 C.F.R. § 404.1512(a).

After describing what is meant by evidence and the claimant's responsibility to provide evidence, the regulation describes the Commissioner's responsibility, in part, as follows:

> Before we make a determination that you are not disabled, we will develop your complete medical history. . . We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports.

20 C.F.R. § 404.1512(d).

The record demonstrates that before any determination was made on Fink's application the Commissioner sought and obtained records from the following providers: Chalmette Delaronde Medical Center (R. 153); Dr. Edmund Landry (R. 156); and,Bogalusa Charity (R. 166). The request to Dr. Landry was dated September 15, 1998 and he provided the notes of his treatment from January 7, 1994 through April 22, 1998. R. 156-64. In the note for April 22, 1998, Dr. Landry reported that Fink was to return in one year "if needed." R. 157. Dr. Landry discussed exercises she could do for weight loss to improve her overall fitness without aggravating her neck and back conditions. R. 157. Dr. Landry's notes do not contain any information on Fink's ability to perform work-related physical activities, and in this respect the medical records were inadequate for the Commissioner to act on Fink's application

> (e) Recontacting medical sources. When the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled, we will need additional information to reach a determination or a decision. To obtain the information, we will take the following actions.
>
> (1) We will first recontact your treating physician or psychologist or other medical source to determine

> whether the additional information we need is readily available. We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques. We may do this by requesting copies of your medical source's records, a new report, or a more detailed report from your medical source, including your treating source, or by telephoning your medical source.

20 C.F.R. § 404.1512(e). Fink contends that the Commissioner was required to recontact Dr. Landry. The Commissioner's letter of September 15, 1998 to Dr. Landry reported to him that his patient had made an application for disability benefits and sought copies of his records or a narrative report. The nature of Fink's alleged disability, back and neck problems, was mentioned and the type of information requested, for example laboratory findings, was described. The letter also requested:

> [A] statement, based on your medical findings, of the claimant's ability to perform work-related physical activities such,as sitting, standing, -walking,_lifting, carrying, handling objects, hearing, speaking, and traveling. R. 156.

In comparison, Bogalusa Charity was only asked to send medical records. R. 166. Notwithstanding the request to Dr. Landry, he did not supply a statement describing Fink's ability to perform work-related physical activities. R. 157-65. By October 13, 1998, the other health care providers had responded to the Commissioner's request for information. R. 166. Prior to November 12, 1998, the Commissioner made the decision to ask Fink to appear for a consultative examination before Dr. Keppel. R. 216-17.

> Need for consultative examination. If the information we need is not readily available from the records of your medical treatment source, or we are unable to seek clarification from your medical source, we will ask you to attend one or more consultative examinations at our expense. . . . Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources.

20 C.F.R. § 404.1512(f). The regulations defines reasonable effort as follows:

> "Every reasonable effort" means that we will make an initial request for evidence from your medical source and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one followup request to obtain the medical evidence necessary to make a determination. The medical source will have a minimum of 10 calendar days from the date of our followup request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

20 C.F.R. § 404.1512(d)(1). These regulations implemented 42 U.S.C. 423(d)(5)(B).[7]

The Commissioner complied with the regulations in contacting the health care providers identified by Fink. Dr. Landry was not only asked to submit his records but he was also asked to provide a statement on his patient's ability to perform

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[7] "In making any determination the Commissioner . . . shall make every reasonable effort to obtain from the individual's treating physician... all medical evidence, including diagnostic tests, necessary in order to properly make such a determination, prior to evaluating medical evidence obtained from any other source on a consultative basis." 42 U.S.C. § 423(d)(5)(B).

work related activities. Dr. Landry, however, declined to do so. The regulations required that the Commissioner make one followup request.[8] The record does not reflect that such a request was sent.

The question remains whether this procedural impropriety casts doubt on the existence of substantial evidence to support the ALJ's decision. Morris v. Bowen, 864 F.2d 333, 335 (5'h Cir. 1988). Because Fink's first four alleged procedural issues are related, this question will be deferred until after their consideration. However, in considering the first four issues raised by Fink, the court will assume that had Dr. Landry been contacted a second time, he would have submitted a report similar to his questionnaire responses of October, 1999: that Fink remained disabled from employment.

Fink contends that instead of requesting that she see Dr. Keppel for a consultative examination, the Commissioner was required to send her to her treating physician, Dr. Landry. The regulations state:

> When in our judgment your treating source is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment, and generally furnishes complete and timely reports, your treating source will be the preferred source to do the purchased examination. Even if only a supplemental test is required, your treating source is ordinarily the preferred source.

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[8]The regulations also provide that, "[w]e may not seek additional evidence or clarification from a medical source when we know from past experience that the source either cannot or will not provide the necessary findings. 20 C.F.R. § 404.1512(e)(2). But for Dr. Landry's failure to provide the requested information in response to the Commissioner's initial request, there is nothing in the record to indicate that he would not have provided the necessary findings if requested to do so in a followup request.

20 C.F.R. § 404.1519h. The question is whether the Commissioner abused his discretion in not arranging a consultative examination with Dr. Landry. In *Meditrust Financial Services Corp. v. Sterling Chemicals, Inc.*, 168 F.3d 211, 215 (5th Cir. 1999), the Fifth Circuit held:

> When reviewing for arbitrary and capricious actions resulting in an abuse of discretion, we affirm an administrator's decision if it is supported by substantial evidence. A decision is arbitrary only if made without a rational connection between the known facts and the decision or between the found facts and the evidence. Assuming that both parties were given an opportunity to present facts to the administrator, our review of factual determinations is confined to the record available to the administrator.

Id. at 215 (citations and quotation marks omitted). The record indicates that Fink was sent to Dr. Landry by her attorney in connection with a claim for damages for personal injuries arising out of a December 16, 1992 accident. Dr. Landry failed to respond to the Commissioner's initial request for a statement of Fink's ability to perform work-related physical activities. There were rational connections to the Commissioner's decision not to pursue an examination with Dr. Landry.

Fink urges that the Commissioner should not have provided Dr. Keppel's report to Dr. Weisberg without recontacting Dr. Landry. The regulation states, "[w]e will not evaluate this evidence (a consultative examination) until we have made every reasonable effort to obtain evidence from your medical sources." 20 C.F.R. § 404.1512(f). The record reveals that the Commissioner did not make the followup request to Dr. Landry. See 20 C.F.R. § 404.1512(e)(1) and (f). However, because Fink obtained responses from Drs. Gessner and Landry prior to the hearing and these were presented to Dr. Weisberg in advance of the hearing, Dr. Weisberg was able to review the

treating physicians' records before the hearing.

Fink contends that in the face of the perceived discrepancies in the records of Drs. Gessner and Landry, the regulations imposed on the ALJ the obligation to recontact the treating sources. The regulations states that, "[w]e will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved." After an introductory description of Fink and her claim, the ALJ thoroughly reviewed the medical evidence, including Dr. Weisberg's testimony. R. 14-19. The ALJ found that the evidence established carpal tunnel syndrome in the right hand but it did not demonstrate: (a) severe cervical or lumbar disc herniation; (b) cardiac, gastrointestinal, or reproductive disease; or (c) an impairment or combination of impairments that met any listing criteria. The ALJ also found that Fink's limitation allegations lacked credibility and that she possessed the residual functional capacity to perform light work activities with moderate limitation of the right hand. R. 19-20.

The questionnaire responses from Drs. Gessner and Landry were in conflict with the opinion of Dr. Keppel. "[C]onflicts in the evidence, including medical opinions, are to be resolved by the Secretary, not by the courts." *Patton v. Schwieker*, 697 F.2d 590, 592 (5`h Cir. 1983). See also *Martinez v. Chater*, 64 F.3d 172, 174 (5`h Cir. 1995). In *Patton* the conflict was between the conclusions of the consulting physician on the one hand and the those of the treating physicians on the other hand. 697 F.2d at 592. It was in order for the ALJ to resolve any conflicts in the medical opinions.

The ALJ found that the questionnaire responses were not substantiated by the medical record. R. 21. In *Scott v. Heckler*, 770 F.2d 482, 485 (5`h Cir. 1985), the Fifth Circuit stated,

The ALJ may give less weight to a treating physician's opinion

when there is good cause shown to the contrary, as is the case when his statement as to disability is "so brief and conclusory that it lacks strong persuasive weight, is not supported by medically acceptable clinical laboratory diagnostic techniques, or is otherwise unsupported by the evidence.
Id. at 485 (citations and quotation marks omitted) and see *Loza v. Apfel*, 219 F.3d 378, 395 (5`h Cir. 2000). It was within the ALJ's province to determine whether the questionnaire responses were substantiated by the medical records.

The only conflicts identified by the ALJ were: (1) Dr. Gessner's questionnaire responses concerning Fink's limitations on sitting versus the statements found in his notes that Fink could perform sedentary secretarial type work (R. 219-20, 227 and 228); (2) Dr. Gessner's responses concerning her severe symptoms and very limited functional ability versus the statements in his notes indicating that surgery was not required (R. 227, 228 and 230); and (3) Dr. Landry's response indicating a sensory loss versus the report in his note of decreased sensation in the right middle finger tip on one occasion (R. 236).

In *Lewis v. Chater*, 1996 WL 43111 (E.D.La.) (Duval, J.), the issue was whether the ALJ was required to recontact the claimant's treating physician. The District Court found that the ALJ resolved the perceived conflicts between the treating physician's notes and a report by the same physician without recontacting the physician. It also found that there was no apparent reason why the physician "could not have been recontacted and it cannot be said that . .. [the treating physician's] notes [which for the most part were illegible] support a finding that his detailed, albeit formulated, report . . . was in error." The conflicts described by the ALJ with the records and questionnaire responses from Drs. Gessner and Landry are similar to those issues that the ALJ was called upon to resolve by Scott v. Heckler. They are not similar to the

illegible notes found in Lewis
v. Chater. The ALJ was not required to recontact Drs. Landry and Gessner because of the conflicts between their questionnaire responses and their notes of treatment.

The only procedural error was the Commissioner's failure to followup with Dr. Landry and this does not cast doubt on the existence of substantial evidence to support the ALJ's decision. *Morris v. Bowen*, 864 F.2d 333, 335 (5th Cir. 1988). Dr. Keppel opined that Fink was able to perform sedentary and light duty activities. R. 217. He reached this conclusion after conducting an examination of Fink on November 2,1998 and reviewing x-rays of her neck and back. R. 216-17. Dr. Keppel's diagnosis was chronic neck and back pain by history but very little in the way of neurologic findings. R. 217. The absence of neurologic findings was supported by the physical examination. R. 216-17. Dr. Weisberg did not examine Fink, but he reviewed the medical records from Drs. Landry, Gessner and Keppel. R. 53. He found no evidence of nerve root or spinal cord compression. It was his opinion that Fink had a soft tissue injury unaccompanied by radiculopathy. R. 55. He cited the reports of muscle spasms as evidence of a soft tissue injury. R. 55. While there was evidence of a right sided carpal tunnel syndrome, there was no evidence of motor dysfunction of the right hand. R. 55-56. Dr. Weisberg did not doubt that Fink was suffering back pain from a soft tissue injury. R. 67. However, he testified that Fink's statements of limiting pain was not supported by findings on examination by her physicians. He stated that, "[w]hen pain is not supported by findings on examination then it tends to be less severe than when it is supported by findings on examination." R. 68.

Pain alone can constitute a disabling impairment, if it is linked to a medically determinable impairment. *Falco v. Shalala*, 27 F.3d 160, 163 (5th Cir. 1994) and *Abshire v. Bowen*, 848 F.2d 638, 642 (5`h Cir. 1988). The pain must be

constant, unremitting, and wholly unresponsive to therapeutic treatment. *Falco v. Shalala*, 27-F.3d 160, 163 (5`h Cir. 1994). Subjective evidence of pain will not take precedence over conflicting medical evidence. *Harper v. Sullivan*, 887 F.2d 92, 96 (5`h Cir. 1989). The medical records and testimony are substantial evidence for the finding that Fink's pain was not disabling. Fink's alleged procedural improprieties do not cast doubt on the existence of this evidence.

Issue No. 5. Did the ALJ err by rejecting the findings of the treating physician without applying the criteria found in 20 C.F.R. § 404.1527(d)(2).

Fink cites *Newton v. Apfel*, 209 F.3d 448 (5`h Cir. 2000), for the proposition that the ALJ was required to consider the six factors found in 20 C.F.R. § 404.1527(d)(2) before rejecting the questionnaire responses from Drs. Gessner and Landry.[9] In *Newton*, the ALJ rejected the opinion of the claimant's treating physician that the claimant could not perform any sedentary work. The Fifth Circuit reversed the decision of the ALJ and stated:

> The Court concludes that, absent reliable medical evidence from a treating or examining physician controverting the claimant's treating specialist, an ALJ may reject the opinion of the treating physician only if the ALJ performs a detailed analysis of the treating physician's views under the criteria set forth in 20 C.F.R. § 404.1527(d)(2)

Newton, 209 F.3d at 453. The ALJ in *Newton* rejected the

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[9]The six factors found in § 404.1527(d) are: (1) the physician's length of treatment of the claimant; (2) the physician's frequency of examination; (3) the nature and extent of the treatment relationship; (4) the support of the physician's opinion afforded by the medical evidence; (5) the consistency of the opinion with the record as a whole; and (6) the specialization of the treating physician.

opinion of the treating physicians and relied on the testimony at the hearing of a medical expert who reviewed the claimant's records but did not examine her. *Newton* does not apply to the ALJ's decision on Fink's claim because there was reliable medical evidence from an examining physician, Dr. Keppel, controverting the answers provided by the treating physicians in the questionnaires.

RECOMMENDATION

Accordingly, IT IS RECOMMENDED that defendant's motion for summary judgment (Rec. doc. 13) be GRANTED and plaintiffs motion for summary judgment (Rec. doc. 12) be DENIED.

OBJECTIONS

A party's failure to file written objections to the proposed findings, conclusions and recommendations in a magistrate judge's report and recommendation within ten (10) days after being served with a copy shall bar that party, except upon grounds of plain error, from attacking on appeal the unobjected-to proposed factual findings and legal conclusions accepted by the district court, provided that the party has been served with notice that such consequences will result from a failure to object. *Douglass v. United Servs. Auto. Ass'n*, 79 F.3d 1415, 1430 (5th Cir. 1996) (*en banc*).

New Orleans, Louisiana, this 11th day of August, 2003.

S/ SALLY SHUSHAN
United States Magistrate Judge

APPENDIX D:

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

MAXANN C. FINK	CIVIL ACTION
VERSUS	NO: 02-2136
JO ANNE B. BARNHART,	SECTION: "B"(1)
COMM. SOCIAL SECURITY ADMINISTRATION	

ORDER

The Court, after considering the complaint, the record, the applicable law, the Magistrate Judge's Report and Recommendation, and plaintiff's objections to same, hereby approves the Magistrate Judge's Report and Recommendation and adopts it as its opinion. Accordingly,

IT IS ORDERED that defendant's motion for summary judgment (Rec. Doc. 13) is GRANTED and the plaintiff's motion for summary judgment (Rec. Doc. 12) is DENIED.

New Orleans, Louisiana, this 26th day of September, 2003.

S/ Ivan M. Lemelle
UNITED STATES DISTRICT JUDGE

APPENDIX E:

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

MAXANN C. FINK	CIVIL ACTION
VERSUS	NO: 02-2136
JO ANNE B. BARNHART,	SECTION: "B"(1)
COMM. SOCIAL SECURITY ADMINISTRATION	

JUDGMENT

The Court having approved the Report and Recommendation of the United States Magistrate Judge and having adopted it as its opinion herein; Accordingly,

IT IS ORDERED, ADJUDGED AND DECREED that there be judgment in favor of defendant, Jo Anne B. Barnhart, Commissioner of the Social Security Administration, and against the plaintiff, Maxann C. Fink, affirming the Commissioner's decision.

New Orleans, Louisiana, this 26th day of September, 2003.

S/ Ivan M. Lemelle
UNITED STATES DISTRICT JUDGE

APPENDIX F:

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals
DECISION

IN THE CASE OF	CLAIM FOR
	Supplemental Security Income
IDA J. ROCHESTER	433-21-5553
(Wage Earner)	(Social Security Number)

The claimant protectively filed an application for supplemental security income benefits on June 15, 1998, at which time she alleged that she was disabled due to mental illness, with an onset date of November 1, 1997. This application was denied initially and on reconsideration. The claimant filed a timely request for a hearing on the matter on April 23, 1999.

A hearing was subsequently scheduled and held before the undersigned Administrative Law Judge on March 23, 2000, in Lafayette, Louisiana. At the hearing the claimant was represented by Attorney John Pintado. The claimant, a medical expert (Dr. Jimmie Cole), and a vocational expert (George E. Hearn) testified at the hearing.

The general issues to be decided in the present case are whether the claimant is "disabled" as defined in the Social Security Act, and if so, the date of onset of such disability and the duration thereof. After carefully studying all of the evidence, it is the conclusion of the undersigned that the claimant does not suffer from an impairment or combination of impairments that meets or equals the requirements of an impairment listed in Appendix 1, Subpart P, Regulations No. 4.

Additionally, the undersigned is convinced that there are jobs existing in significant numbers in the economy the claimant can perform despite her alleged impairments. Therefore, it is the decision of the undersigned that the claimant is not disabled (Section 416.920(d)).

Pursuant to section 404.1520, a sequential evaluation is required in disability cases. First, an individual who is engaging in substantial gainful activity cannot be found to be disabled. Second, an individual who does not suffer from a severe impairment or combination of impairments is not disabled. Third, an individual who suffers from an impairment that meets or equals the requirements of an impairment listed in Appendix 1, Subpart P, will found to be disabled without consideration of vocational factors. Fourth, a determination must be made as to whether the individual can perform his or her past relevant work. If not, the burden shifts to the Administration to demonstrate that, given the individual's age, education, past relevant work experience, and residual functional capacity, there are other jobs existing in significant numbers in the economy that the individual can perform.

Determining the effect of pain and other subjective symptoms on the claimant's residual medical condition is present that could reasonably be expected to produce the symptoms alleged. Consideration must be given to the claimant's work record, medical history and treatment (including medication effects and side0effects), daily activities, pain and symptoms, and precipitating/aggravating factors, and observations made by others
(section 404.1529).

The evidence reveals that the claimant was born on March 3, 1972. Thus, she is presently 28 years old, which is considered to be a younger "individual" (section 416.963). The claimant has completed a marginal, sixth grade education and she has no past relevant work experience. Consistent with her past relevant

work history (none) the claimant has not engaged in substantial gainful activity at any time at issue in her case.

The claimant's testimony at her hearing indicated that she believes that she is unable to work due to chronic panic attacks and paranoia. She complained of poor sleep and variable appetite. The claimant's testimony indicated that she lives with her sister and that she prefers to stay at home. The claimant also complained of chest pain, shortness of breath and a heart murmur. She alleged that she becomes paranoid when she leaves her home and she contended that she presently is experiencing visual hallucinations. The claimant informed the undersigned that she continues to take medication therapy for her mental health problems. She denied any significant side effects of medication therapy. In response to questioning by the undersigned, the claimant reported that her ability to engage in basic physical work activities is not impaired. However, she complained of poor concentration, poor stress tolerance, and poor memory. The medical evidence indicates that the claimant has a history of poor performance in school, and consistent with her testimony, she apparently ceased her educational efforts after the sixth grade. However, the record does not document that the claimant is suffering from mental retardation.

Her current treating physician is Dr. S. Young, who has indicated that the claimant is suffering from a panic disorder with agoraphobia and paranoid schizophrenia (Exhibits 8F, 11F, 13F). The claimant is presently prescribed Risperdal, Paxil, and Trazodone for her mental health problems and her related complaints of panic attacks, general nervousness and paranoia. The claimant has informed Dr. Young on occasion that she is experiencing auditory hallucinations. However, the undersigned's review of the record does not reveal that the claimant has ever informed the doctor that she is experiencing visual hallucinations (as alleged at her hearing). Dr. Young has

treated the claimant since the fall, 1998, and he has reported that he believes that the claimant is experiencing a wide range of functional limitations due to her mental health problems, including marked restrictions in her activities of daily living, marked limitations in her ability to maintain social functioning, and frequent failures to complete tasks in a timely manner due to deficiencies of concentration, persistence or pace (Exhibit 11F). The doctor has also advised that the claimant is subject to continual episodes of deterioration or decompensation if she is placed in work or work-like settings. Consistent with his expert opinion, he has opined that the claimant is experiencing a substantial loss of her ability to understand, carry out or remember even simple job instructions.

It appears that Dr. Young has largely relied on the self-reports of the claimant when evaluating the nature and severity of the claimant's mental health impairments. However, the record indicates that the claimant is not a particularly reliable informant. She was briefly hospitalized from June 29, 1988 through July 1, 1998, for treatment of an alleged panic disorder (Exhibit 2F). However, at the time of her hospitalization the claimant reported that she had been encouraged to report false symptoms in order to obtain disability benefits. Contact with the claimant's mother indicated that she was unaware that the claimant was experiencing any significant mental health symptoms. Consistent with her mother's report, the claimant also denied that she was in need of inpatient mental health treatment. Additionally, the claimant was reported to indicate that she was poorly motivated to work ("lazy and not wanting to work"). Additionally, when seen for consultative psychological evaluation by Dr. A. Buxton in October 1998, the claimant exhibited selective recall secondary to low motivation (Exhibit 5F). Dr. Buxton found it to be "quite obvious" the claimant was exhibiting evidence of manipulation and secondary gain during her mental status

examination. For example she informed the doctor that she believed a mouse was bigger than a cat, the only color she could recall in the American flag was white. Dr. Buxton offered a G.A.F. rating of 70 which reflected that he did not believe that the claimant was suffering from any severe, disabling psychopathology.

As previously noted, a medical expert, Dr. Jimmie Cole, was also present and testified at the claimant's hearing. He indicated that it was his opinion that the claimant is not suffering from an impairment or combination of impairments that meets or equals the requirements of an impairment listed in Appendix 1, Subpart P, Regulations No. 4. Additionally, his testimony reflected that the claimant should be capable of simple jobs involving 1 or 2 step tasks with no high levels of stress and no regular contact with the public or large number of co-workers. Subsequent to the testimony of Dr. Cole, the vocational expert at the claimant's hearing, Mr. Hearn, indicated that, given the claimant's age, education, past relevant work experience, and basic mental work capabilities as described by Dr. Cole, there would be jobs existing in significant numbers in the economy that the claimant could perform. These jobs included numerous housekeeper/cleaner positions and unskilled assembler positions.

It is the conclusion of the undersigned that the above-summarized record demonstrates that the claimant is suffering from panic attacks. The present record does not objectively document that she is suffering from a severe thought disorder or schizophrenia nor does the instant record objectively demonstrate that she is suffering from any severe physical impairments. The claimant's presentation and demeanor on the date of the hearing were not, in the undersigned's opinion, consistent with the presence of a disabling mental impairment. Also, the medical expert's testimony at the claimant's hearing did not reflect that the claimant is suffering from a disabling

mental impairment. The claimant's treating physician's expert opinion would generally be entitled to controlling weight. However, the present record contains substantial evidence that is contrary to Dr. Young's expert opinions. In particular, the undersigned again notes that Dr. Young appears to rely heavily on the claimant's self-reports relative to the nature and severity of her mental health problems. However, the record contains significant evidence that indicates that the claimant is not a reliable informant. Accordingly, the undersigned adopts the expert opinion of Dr. Cole and finds that the claimant is capable of performing simple, low stress jobs that involves one or two step tasks and do not require significant interaction with the public or large numbers of coworkers.

Because the claimant has no past relevant work experience, the burden of proof is on the Administration to demonstrate that there are jobs existing in significant numbers in the economy that the claimant can perform. It is the conclusion of the undersigned that the Administration has met this burden.

As previously noted, the claimant is a "younger individual" with a "marginal" educational history. She has no past relevant work history and is subject to no limitations in her ability to meet the exertional demands of work. Thus, Section 204.00 of Appendix 2, Subpart P, Regulations No. 4 indicates that a finding of "not disabled" the limitations and her ability to meet the mental demands of work do not significantly compromise her ability to perform work at all exertional levels.

The vocational expert testimony received at the claimant's hearing indicates that the claimant's impairment-related limitations do not significantly compromise the claimant's ability to perform work activities at all levels. Presented with a hypothetical person of the claimant's profile, limited as herein found, Dr. Hearn opined that such a person could perform the jobs of housekeeper/cleaner/steward, or

assembly line worker. Based on personal observation of the claimant at her hearing and a careful review of all of the evidence, the undersigned is convinced that the claimant can perform the jobs cited by the vocational expert in response to the hypothetical questions posed by the undersigned. Accordingly, using Section 204.00 as a framework for decisionmaking and pursuant to Section 416.920(f), it is the decision of the undersigned that the claimant is not disabled as there are jobs existing in significant numbers in the economy that she remains capable of performing. Consistent with the regulations concerning the evaluation of mental impairments, a completed Psychiatric Review Technique Form is attached to this decision and reflects the undersigned's conclusion that the claimant is not suffering from a disabling mental impairment.

FINDINGS

After carefully considered all of the evidence, the Administrative Law Judge makes the following findings:

1. The claimant has not engaged in substantial gainful activity at any time at issue in her case.
2. The medical evidence establishes that the claimant suffers from panic attacks, but that she does not have an impairment or combination of impairments listed in or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4.
3. The claimant's allegations relative to the nature and severity of her alleged impairments are found to be not credible.
4. The claimant's history of panic attacks does not prevent her performance of unskilled, routine jobs that involve 1 or 2-step job tasks and that are low stress in nature and that does not require significant interaction with the public or large numbers of co-workers.
5. The claimant has no past relevant work experience.

6. The claimant is 28-years old, which is defined as a "younger individual" (Section 416.963).
7. The claimant has completed a "marginal" 6th grade education (Section 416.964).
8. The claimant has no transferable work skills.

9. The claimant's limitations do not significantly compromise her ability to perform work at all levels, Section 204.00 of Appendix 2, Subpart P, Regulations No. 4 indicates that a finding of not disabled would be appropriate. If her capacity to work at all levels were significantly compromised, the remaining work which she would functionally be capable of performing would be considered in combination with her age, education and work experience to determine whether a work adjustment could be made.
10 Considering the range of work at all levels which the claimant is still capable of performing, in combination with her age, education and work experience, and using Section 204.00 as a framework for decision making, the claimant is not disabled.
11. The claimant was not under a "disability" as defined in the Social Security Act, at any time through the date of this decision (Section 416.920(f)).

DECISION

It is the decision of the Administrative Law Judge that, based on the application protectively filed on June 15, 1998, the claimant is not eligible for supplemental security income under Sections 1602 and 1614(a)(3)(A) of the Social Security Act.

S/E. Wilson Crump II
Administrative Law Judge
August 23, 2000

APPENDIX G:

ACTION OF APPEALS COUNCIL
ON REQUEST FOR REVIEW

Ms. Ida Rochester
409 Malvern Ave.
Rayne, LA 70578

Dear Ms. Rochester:

The Appeals Council hereby vacates its prior action of August 8, 2002, denying the request for review of the Administrative Law Judge's decision issued on August 23, 2000, to consider further arguments.

Social Security Administration regulations provide that the Appeals Council will grant a request for review where: (1) there appears to be an abuse of discretion by the Administrative Law Judge; (2) there is an error of law; (3) the Administrative Law Judge's action, findings, or conclusions are not supported by substantial evidence; or (4) there is a broad policy or procedural issue which may affect the general public interest. The regulations also provide that where new and material evidence is submitted with the request for review, the entire record will be evaluated and review will be granted where the Appeals Council finds that the Administrative Law Judge's actions, findings, or conclusion is contrary to the weight of the evidence currently of record (20 CFR 416.1470).

The Appeals Council has concluded that there is no basis under the above regulations for granting your request for review. Accordingly, your request is denied and the Administrative Law Judge's decision stands as the final decision of the

Commissioner of Social Security in your case. In reaching this conclusion, the Appeals Council has considered the applicable statutes, regulations, and rulings in effect as of the date of this action.

The Appeals Council has also considered the contentions raised in the material identified on the attached Order of Appeals Council, but concluded that these contentions do not provide a basis for changing the Administrative Law Judge's decision.

If you desire a court review of the Administrative Law Judge's decision, you may commence a civil action by filing a complaint in the United States District Court for the judicial district in which you reside within sixty (60) days from the date of the receipt of this letter. It will be presumed that this letter is received within five (5) days after the date shown above unless a reasonable showing to the contrary is made. The complaint should name the Commissioner of Social Security as the defendant and should include 2

the Social Security number(s) shown at the top of this notice. The right to court review is provided for in section 1631(c)(3) of the Social Security Act (42 U.S.C. 1383(c)(3)).

If you cannot file your complaint within 60 days, you may ask the Appeals Council to extend the time in which you may begin a civil action. However, the Council will only extend the time if you provide a good reason for not meeting the deadline. Your reason(s) must be set forth clearly in your request.

If a civil action is commenced, the Commissioner must be served by sending a copy of the summons and complaint by registered or certified mail to the General Counsel, Social Security Administration, Room 611, Altmeyer Building, 6401

Security Boulevard, Baltimore, MD 21235. (See rules 4(c) and (i) of the Federal Rules of Civil Procedure). In addition, you must serve the United States Attorney for the district in which you file your complaint and the Attorney General of the United States, as provided in the Federal Rules of Civil Procedure.

Sincerely yours, original signed by

S/Richard Ross
Acting Appeals Officer
December 17, 2002

cc:
Paul Brian Spurlock, Esq.

APPENDIX H:

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA
LAFAYETTE-OPELOUSAS DIVISION

IDA J. ROCHESTER	CIVIL ACTION
VERSUS	NO: 02-2114
JO ANNE B. BARNHART,	JUDGE DOHERTY
COMM. SSA	MAG. JUDGE HILL

REPORT AND RECOMMENDATION

This social security appeal was referred to me for review, Report and Recommendation pursuant to this Court's Standing Order of July 8, 1993. Ida J. Rochester, born March 3, 1972, filed an application for supplemental security income on June 15, 1998, alleging disability as of November 1, 1997, due to mental illness.

FINDINGS AND CONCLUSIONS

After a review of the entire administrative record and the briefs filed by the parties, and pursuant to 42 U.S.C. § 405(g), I find that there is substantial evidence in the record to support the Commissioner's decision of non-disability and that the Commissioner's decision comports with all relevant legal standards. Anthony v. Sullivan, 954 F.2d 289, 292 (5th Cir. 1992).

In fulfillment of F.R.Civ.P. 52, I find that the Commissioner's findings and conclusions are supported by substantial evidence, which can be outlined as follows:

(1) Records from Pauline Faulk Centre for Behavioral Health dated June 29 to July 1, 1998. Claimant was referred for

inpatient treatment from the Crowley Mental Health Clinic. (Tr. 155). She claimed that she "was encouraged to give false symptomatology in order to get disability." She stated that when she did this, she had been "forced" to come over for admission. She endorsed a history of depression that was treated in the remote past, as well as symptoms consistent with panic attacks beginning the previous fall. She also had begun isolating herself. (Tr. 158).

On admission, claimant denied suicidality, homicidality, and all reportable psychotic symptoms. (Tr. 155). She had no significant abnormalities on mental status examination.

On examination, claimant's thought process was goal directed. (Tr. 159). Her mood was little anxious. Her affect was full range and appropriate to content. She denied all reportable psychotic symptoms, and had no overt evidence of psychosis. She was oriented to person, place, time and day of the week. Insight into reason for admission or referral was limited. Judgment to theoretical social constructs was good.

Dr. Kevin Young's diagnostic impression was panic disorder with agoraphobia and depressive disorder, NOS. (Tr. 155). Claimant was continued on Zoloft and started on Klonopin. (Tr. 156). Her prognosis was fair.

(2) Records from Crowley Mental Health Center dated February 19 to August 17, 1998. On February 19, 1998, claimant presented with a history of major depression which had recurred, and disabling panic attacks. (Tr. 169). Her intelligence was estimated as minimal. Her orientation, memory, thought content, thought processes, speech and psychomotor activity all appeared normal. Affect was appropriate, mood was depressed, and suicidal ideation was present.

Claimant's diagnosis was major depression, recurrent, moderate, without psychotic features, panic disorder with agoraphobia, and obesity. (Tr. 170). Her Global Assessment of

Functioning score was 55. The plan was to treat her with antidepressant chemotherapy. (Tr. 169).

A transcription note dated August 17, 1998, stated that claimant had not been seen since June 29, and that she had failed to keep her scheduled appointment on July 13, 1998. (Tr. 163).

(3) Consultative Psychological Examination by Dr. Alfred E. Buxton dated October 14, 1998. Claimant denied any significant depression or panic attacks, but instead described "rather diffused nervousness" that "lasted all day." (Tr. 173). She also reported memory deficits for the last three years.

In reviewing claimant's medical records, Dr. Buxton found it interesting that "throughout many of these notes reference is made to the fact that she indicated she was lazy and did not particularly care to work and that she was certainly seeking being placed on SSI benefits." He noted that "[o]ne gets the impression that she was somewhat goal oriented and perhaps secondary gain was motivating her seeking treatment."

On examination, claimant had no indication of any sensory or motor handicaps. (Tr. 174). Verbal receptive and expressive language skills were good, and social skill was adequate. Recent and remote memories were good for those things which she desired to recall, and somewhat poor for those that she desired not to recall. Dr. Buxton noted that this seemed "to be rather elective on her behalf."

Claimant's ability to attend and concentrate was adequate for on-task purposes. Her pace was even with a regular rate of performance. Intellect was a bit subaverage, but no worse than borderline and probably dull normal or low average. Judgment and reflective cognition were fair. Reasoning was fair, and claimant was oriented towards the concrete, obvious and simple. Insight was poor. Cognitions were clear and cogent. Mood was even.

Claimant complained of seeing spots and hearing people

calling her name, but nothing that would indicate any hallucinatory experience. Although claimant indicated that she felt "paranoid," Dr. Buxton noted that there was nothing elicited which would indicate a paranoid belief system. She denied suicidal or homicidal ideation.

Goal orientation was somewhat questionable. Dr. Buxton noted that again, there was some evidence to suggest that she was being somewhat manipulative, and that issues of secondary gain were motivating her responses. He observed that she gave some wrong information despite the fact that she could provide all other relevant demographic and historical information. He noted that it was "[q]uite obvious that this is selected memory and again issues of secondary gain seem to be motivating her response."

Dr. Buxton concluded that claimant's adaptive daily living skills were within acceptable limits of general expectancy. (Tr. 174-75). He suspected that she was competent as a manager of her own personal affairs, although she reported that she was somewhat dependent on others. (Tr. 175). He noted that there was nothing evidenced on that occasion which would lead to the diagnoses of major depression and panic disorder with agoraphobia. At best, he found that she would have a generalized anxiety disorder with degree of impairment mild to moderate and prognosis fair, and a dysthymic disorder. He noted that "[e]ven these diagnoses are somewhat tentative as issues of secondary gain seem to be strongly motivating the performance and presentation of this individual on this occasion." The G.A.F. score was 70 over the last 12 months, and quite possibly even higher.

(4) Psychiatric Review Technique ("PRT") dated October 28, 1998. Claimant was assessed for anxiety related disorders and chronic pain disorder. (Tr. 178). Dr. B. R. Burgoyne determined that she had a slight degree of limitation as to restriction of activities of daily living and difficulties in

maintaining social functioning. (Tr. 185). There was insufficient evidence of other limitations.

(5) Records from Dr. Vivek Jain and Dr. Mandana Hashefi dated September 23 to December 23, 1998. Claimant had seen Dr. Hashefi on September 23, 1998 for a general check up and complaints of an upper respiratory tract infection. (Tr. 187, 190). She was seen by Dr. Jain on November 20, 1998 for a twisted right ankle. (Tr. 187, 189-90). X-rays revealed no fractures, and she was treated with a right foot splint for three weeks and Ibuprofen.

At a return visit on December 15, claimant had recovered remarkably. (Tr. 187). On examination, she had no abnormalities in the right lower extremity, and gait was normal.

Dr. Jain noted that claimant had multiple psychiatric problems, including depression, for which she was being followed by Dr. Young.

(6) Records from Dr. Kevin Young dated July 14, 1998 to March 1, 1999.[1] On July 14, 1998, claimant reported no full-blown panic attacks since her release from the hospital on July 1. (Tr. 212). Initially, she was doing well, but began to deteriorate by September 18, 1998. (Tr. 201).

On October 20, claimant described psychotic symptoms for the first time, including paranoia and auditory hallucinations. (Tr. 201, 207). At that session, she had a slightly disorganized thought process with loose associations. She was diagnosed with schizophrenia, paranoid type, and started on a low dose of anti-psychotic medication. (Tr. 202).

On November 6, 1998, claimant reported having more panic attacks in the prior week after her Zoloft was decreased. (Tr. 202, 204-05). She again began having a fear of leaving the house, and had become essentially confined to her living space.

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[1]These records are largely illegible.

At one point, she had her sister take care of her children because of the degree of anxiety and paranoia.

On November 20, 1998, claimant's Risperdal was increased. (Tr. 202-03). Her medication for panic attacks was changed from Zoloft to Paxil. She was also taking Diazepam.

Dr. Young's impression was schizophrenia, paranoid type; panic disorder with agoraphobia, and obesity. (Tr. 202). Her GAF was 50.

On December 18, claimant reported continued problems with hallucinations and paranoid ideation. (Tr. 199, 200). Her anti-psychotic medication was increased. Dr. Young noted that claimant's panic attacks had been fairly well controlled with Paxil and Diazepam.

As to physical abilities, Dr. Young determined that claimant could sit, stand; walk, lift, carry, and handle objects. (Tr. 199, 202). She had no difficulty with hearing or speaking. Due to her paranoia and agoraphobia, traveling was unlikely. Dr. Young stated that claimant was able to understand her diagnosis and the purpose of her medications. (Tr. 202). On formal cognitive testing, she did not seem to have any significant memory problems. Her overall level of cognitive capacity was not too impaired. (Tr. 199).

Claimant understood information about her treatment fairly well. Dr. Young stated that her understanding generally was good, and her memory was intact. She did have some problems with concentration and attention due to her psychotic symptomatology. However, her thought processes were fairly goal-directed.

Dr. Young observed, that, due to paranoia at that time, claimant had some problems with appropriate socialization. He noted that she tended to be quite isolated, and left her house very little. Dr. Young stated that claimant's adaptation to new environments was fairly impaired.

(7) Mental Residual Functional Capacity Assessment

dated March 8, 1999. Claimant was found to be moderately limited in her ability to understand and remember detailed instructions, carry out detailed instructions, maintain attention and concentration for extended periods, complete a normal workday and workweek without interruptions, interact appropriately with the general public, and set realistic goals or make plans independently of others. (Tr. 214-15).

(8) PRT dated March 8, 1999. Claimant was assessed for schizophrenia, paranoid type, and panic disorder with agoraphobia. (Tr. 218-19). Dr. John M. Boutte noted that claimant continued to receive psychiatric treatment and medication with fair control of symptoms. (Tr. 219).

(9) Medical Assessment by Dr. Young dated September 23, 1999. Dr. Young indicated that claimant had agoraphobia which was sufficiently severe to preclude her leaving home alone on a daily basis to go to work. (Tr. 228). He checked that she had medically documented persistence of delusions or hallucinations, incoherence, loosening of associations, illogical thinking, or poverty of content of speech, blunt affect, and emotional withdrawal and/or isolation. (Tr. 229). He noted that she had marked restriction of activities of daily living and difficulties in maintaining social functioning. Additionally, she had frequent deficiencies of concentration, persistence or pace. Dr. Young reported that claimant had had repeated episodes of deterioration or decompensation and a documented current history of two or more years of inability to function outside of a highly supportive living situation. (Tr. 230). He opined that claimant was disabled from competitive, full-time employment. He noted that she had demonstrated a substantial loss of ability to understand, carry out or remember simple instructions, respond appropriately to supervision, coworkers or usual work situations, or deal with changes in the routine work settings.

(10) Records from Dr. Young dated August 18, 1999 to

March 29, 2000.[2] On August 18, 1999, claimant reported fear of leaving her house and riding in cars. (Tr. 232). She felt that someone was outside of her house waiting to get in. She also reported having some difficulty sleeping.

On March 1, 2000, claimant reported that her panic attacks had come back. (Tr. 234). She also complained of hearing voices. She had insomnia, was easily fatigued, and had decreased appetite, but no weight loss.

On March 29, 2000, claimant reported that she continued to have panic attacks three times a day within one half hour. (Tr. 235). She complained that she was getting so paranoid that she could hardly leave her house. Additionally, she stated that she was not really depressed, but "real nervous." Claimant's diagnosis was schizophrenia, paranoid type, and panic disorder with agoraphobia. The plan was to increase her Paxil and Risperdal and add Trazodone.[3]

(11) Claimant's Administrative Hearing Testimony. At the hearing on March 23, 2000, claimant was 28 years old. (Tr. 42). She was 5 feet 3 inches tall and weighed 290 pounds. She had completed the sixth grade. She had finished training as a nursing assistant. (Tr. 43-44).

Claimant testified that she had last worked as a crawfish peeler for three to four months, but stopped working after she became ill. (Tr. 44). She had also worked for one month as a nurse's aide, but had quit because she could not follow instructions.

As to daily activities, claimant testified that she got her two children up and dressed them every day. (Tr. 45). She reported very bad anxiety attacks twice daily which lasted half

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[2]Some of these records are illegible.

[3]Used to relieve mental depression and depression that sometimes occurs with anxiety.

an hour. She stated that she did not do housework, and basically just sat around and watched television all day. (Tr. 46).

Claimant reported that she did not visit people or leave the house, except with her sister. (Tr. 46, 56). She stated that she could not sleep, because she was scared. (Tr. 47). She said that she ate just one time a day. She complained that she had nausea after her panic attacks.

Claimant testified that during the panic attacks, her chest hurt and she could not breathe. She stated that she started having them around 1989, and that they had become worse. (Tr. 48). She reported that the longest she had gone without having one was about two or three weeks.

Additionally, claimant complained that she had paranoia. (Tr. 49). She said that she heard voices daily. She testified that she was taking Risperdal, but that it did not work too well. She stated that she did not really have any side affects from her current medications, which also included Paxil. (Tr. 52, 58).

Claimant also testified that she had memory loss. (Tr. 50). Additionally, she complained of a heart muunur, which caused chest pain.

As to restrictions, claimant testified that she did not have difficulty with standing, walking, or using her arms and hands. (Tr. 52). She had problems with memory and thinking. It also bothered her to be around crowds. (Tr. 53). Additionally, she reported that she had allergies. (Tr. 54).

(12) Administrative Hearing Testimony of Dr. Jimmie D. Cole, Medical Expert. Dr. Cole testified that based on claimant's medical records, she would be classified under § 12.06 of the listings for panic disorder and generalized anxiety disorder. (Tr. 67). He noted that there were some inconsistencies in the record, which indicated less than the listing level of impairment under the B criteria. (Tr. 68). Additionally, he stated that the C criteria were absent.

Regarding restrictions, Dr. Cole testified that claimant would be limited by her education. (Tr. 69). He opined that she would need to have an occupation that would require one or two-step commands, avoid high stress situations such as working under a quota system, and avoid large groups. He commented that he was not sure why she was taking medications when she had indicated that her medications were not helping and that her condition did not deteriorate while she was off of them for four months. (Tr. 70).

(13) Administrative Hearing Testimony of Dr. George Hearn, Vocational Expert. Dr. Hearn classified claimant's past work as a crawfish peeler as light and unskilled, and a nursing assistant as medium and unskilled. (Tr. 73-74). He noted that she had very minimal vocational experience and no true transferable skills. (Tr. 74).

The ALJ posed a hypothetical in which he asked the expert to assume a claimant of the same age, education and vocational background who had no exertional limitations, who would be precluded from performing highly detailed or complex work, but could perform at least one to two-step operations under general supervision, who would be precluded from work with high stresses, such as production quotas, and who would be precluded from work that would require regular interaction with the general public and large groups, but not small groups, of coworkers. In response, Dr. Hearn testified that such claimant could work as a housekeeper and cleaner, of which there were 250,000 light jobs nationally and 4,000 to 5,000 statewide; or assembly line worker, of which there were 500,000 light or sedentary jobs nationally and 10,000 statewide. (Tr. 74-75). When the ALJ modified the hypothetical to include daily panic attacks, Dr. Hearn testified that there would be no jobs available. (Tr. 75).

(14) The ALJ's Findings are Entitled to Deference. Claimant argues that the ALJ erred: (1) in rejecting the findings

of the treating psychiatrists without complying with 20 C.F.R. § 1512(e)(1) (recontacting medical sources); (2) in rejecting the findings of the treating psychiatrists without complying with 20 C.F.R. § 404.1527(d)(2) (weighing treatment relationship); (3) in substituting his medical assessment of plaintiff's psychiatric condition for that of the treating psychiatrists; (4) in ordering a consultative examination by a non-treating psychologist without attempting to have it performed by a treating psychiatrist; (5) in failing to address the written testimony of plaintiff's sister; and (6) that the Appeals Council failed to address plaintiff's arguments.

As to first error, claimant argues that the ALJ erred in rejecting Dr. Young's opinion without recontacting him for clarification as to why he considered claimant disabled, citing *Newton v. Apfel*, 209 F.3d 448 (5th Cir. 2000). *Newton* states that if the ALJ determines that the treating physician's records are inconclusive or otherwise inadequate to receive controlling weight, absent other medical opinion evidence based on personal examination or treatment of the claimant, the ALJ must seek clarification or additional evidence from the treating physician in accordance with 20 C.F.R. § 404.1512(e). (emphasis added). Id. at 453. Here, however, there is other medical opinion evidence based on personal examination or treatment of the claimant – namely, from Dr. Buxton. (emphasis added).

Claimant argues that the ALJ erred in giving greater weight to the opinion of Dr. Buxton rather than to those of the treating physicians. The ALJ rejected Dr. Young's opinion on the grounds that Dr. Young had largely relied on the self-reports of the claimant, while the record indicated that claimant was not a particularly reliable informant. (Tr. 21). He noted that, at the time of her hospitalization, claimant reported that she had been encouraged to report false symptoms in order to obtain benefits. (Tr. 155). Additionally, the ALJ cited Dr. Buxton's opinion that

claimant had exhibited evidence of manipulation and secondary gain during mental status examination. (Tr. 22, 173-74).

It is well established that the opinion of a treating physician who is familiar with the claimant's impairments, treatments and responses, should be accorded great weight in determining disability. *Newton v. Apfel*, 209 F.3d 448, 455 (5th Cir. 2000); *Leggett v. Chater*, 67 F.3d 558, 566 (5th Cir. 1995); *Greenspan v. Shalala*, 38 F.3d 232, 237 (5th Cir. 1994), cert. denied, 514 U.S. 1120, 115 S.Ct. 1984, 131 L.Ed.2d 871 (1995). A treating physician's opinion on the nature and severity of a patient's impairment will be given controlling weight if it is "well supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with ... other substantial evidence." *Newton*, 209 F.3d at 455 (citing 20 C.F.R. § 404.1527(d)(2)). Even though the opinion and diagnosis of a treating physician should be afforded considerable weight in determining disability, "the ALJ has sole responsibility for determining a claimant's disability status." *Id.* (citing *Paul v. Shalala*, 29 F.3d 208, 211 (5th Cir. 1994)). "'[T]he ALJ is free to reject the opinion of any physician when the evidence supports a contrary conclusion.'" *Id.*

While there are reports in the record indicating that claimant had mental problems, the ALJ was free to reject those opinions. The ALJ discounted Dr. Young's findings that claimant had disabling impairments on the grounds that he relied primarily on her self-reports. (Tr. 21). Instead, he relied upon Dr. Buxton's opinion that claimant was motivated by secondary gain issues. Indeed, Dr. Buxton indicated throughout his report that claimant's motivation was less than sincere, citing the observation that she "was certainly seeking being placed on SSI benefits;" that she "was somewhat goal oriented and perhaps secondary gain was motivating her seeking treatment;" that her recent and remote memories seemed "to be rather elective on her behalf;" that "there is some evidence to

suggest that she is being somewhat manipulative and issues of secondary gain are motivating her responses," and that, in terms of orientation, it was "[q]uite obvious that this is selected memory and again issues of secondary gain seem to be motivating her response." (Tr. 173-74). As the evidence supports a contrary conclusion, the ALJ was free to reject the opinion of claimant's treating physician.

Additionally, claimant argues that, in rejecting the opinions of the treating physician, the ALJ was required to perform a detailed analysis of the treating physician's views under the criteria set forth in 20 C.F.R. § 404.1527(d)(2)[4] as required by *Newton*, supra. In Newton, the Fifth Circuit held that, "absent reliable medical evidence from a treating or examining physician controverting the claimant's treating specialist, an ALJ may reject the opinion of the treating physician only if the ALJ performs a detailed analysis of the treating physician's views under the criteria set forth in 20 C.F.R. § 404.1527(d)(2). (emphasis added). Here, however, there is evidence from an examining physician – namely, Dr. Buxton. Unlike Newton, this is not a case where the ALJ summarily rejected the opinions of claimant's treating physician, based only on the testimony of a non-specialty medical expert who had not examined the claimant. Thus,

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[4]Specifically, this regulation requires consideration of:
(1) the physician's length of treatment of the claimant,
(2) the physician's frequency of examination,
(3) the nature and extent of the treatment relationship,
(4) the support of the physician's opinion afforded by the medical evidence of record,
(5) the consistency of the opinion with the record as a whole; and
(6) the specialization of the treating physician.

claimant's argument lacks merit.[5]

Further, claimant argues that the ALJ "substituted" his medical assessment of plaintiff's psychiatric condition for that of the treating psychiatrists. However, among the opinions by treating doctors that have no special significance are determinations that an applicant is "disabled" or "unable to work." Frank v. Barnhart, 326 F.3d 618, 620 (5th Cir. 2003) (citing 20 C.F.R. § 1527(e)(1)). These determinations are legal conclusions that the regulation describes as "reserved to the Commissioner." Id. As the ALJ, not the treating physician, has sole responsibility for determining a claimant's disability status, this argument lacks merit. Newton, 209 F.3d at 455.

Next, claimant argues that the ALJ relied upon a

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[5]Claimant cites *Trahan v. Barnhart*, Docket No. 02-1136 (W.D. La. [Lake Charles Division] July 2, 2003), in support of her argument that an ALJ is required to consider each of the § 404.1527(d) factors before declining to give any weight to the opinions of the claimant's treating specialist, even where a non-specialty expert had examined the claimant. *Trahan*, which is an unpublished opinion from outside of this division, is non-binding on this Court. Other district courts have declined to expand *Newton*. See, *Alejandro v. Barnhart*, --- F.Supp.2d ---, 2003 WL 22717702, *18 (S.D.Tex., 2003) (citing *Castille v. Barnhart*, No. Civ. A. 01-2664, 2002 WL 1900815, at *6 (E.D.La. Aug.13, 2002) (unpublished opinion) (stating that Newton is limited to situations where contrary reliable medical evidence from a treating or examining physician is not available); *Contreras v. Massanari*, No. Civ. A. 1:000V242, 2001 WL 520815, at *4 (N.D.Tex. May 14, 2001) (unpublished opinion) ("*Newton* is limited to circumstances where the administrative law judge summarily rejects the opinions of a claimant's treating physician, based only on the testimony of a non-specialty medical expert who had not examined the claimant."); *Frank v. Massanari*, No. Civ. A. 99-3038, 2001 WL 664594, at *3 (E.D.La. June 12, 2001) (unpublished opinion) (distinguishes *Newton* as applying to situations "in which there is no competing first-hand medical evidence on which an administrative court can base its factual determination")).

consultative examination by a non-treating psychologist without attempting to have it performed by a treating psychiatrist, citing 20 C.F.R. § 404.1519h, which provides:

> When in our judgment your treating source is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment, and generally furnishes complete and timely reports, your treating source will be the preferred source to do the purchased examination. Even if only a supplemental test is required, your treating source is ordinarily the preferred source.

Claimant argues that this statute requires the ALJ to use only the treating physician for consultations. She urges that the ALJ therefore erred by not using Dr. Young for the additional examination. However, 20 C.F.R. § 404.1519(h) is not the only regulation that governs physician consultations. 20 C.F.R. § 404.1512(f) supplies the general regulations regarding the need for consultative examinations. It states:

> If the information we need is not readily available from the records of your medical treatment source, or we are unable to seek clarification from your medical source, we will ask you to attend one or more consultative examinations at our expense.... Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. However, in some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

Further, 20 C.F.R. § 404.1517 provides that:

> If your medical sources cannot or will not give us sufficient medical evidence about your impairment for us to determine whether you are disabled or blind, we may ask you to have one or more physical or mental examinations or tests. We will pay for these examinations. However, we will not pay for any medical examination arranged by you or your representative without our advance approval. If we arrange for the examination or test, we will give you reasonable notice of the date, time, and place the examination or test will be given, and the name of the person or facility who will do it. We will also give the examiner any necessary background information about your condition.

Neither these two regulations, nor any other regulation, requires that the treating physician act as the only consulting physician. Thus, this argument lacks merit.

Next, claimant argues that the ALJ failed to address the written testimony of her sister. The record reflects that the ALJ left the record open at the hearing to receive a short statement from claimant's sister. (Tr. 78). Such statement is contained on pages 122 and 123 of the transcript. The ALJ did not indicate whether he had reviewed this letter in making his decision.

In support of claimant's argument that the ALJ should have considered this statement, claimant cites *Smith v. Heckler*, 735 F.2d 312, 317 (8th Cir. 1984), in which the court stated: "[w]e have frequently criticized the failure of the Secretary to consider subjective testimony of the family and others. We have held that a failure to make credibility determinations concerning such evidence requires a reversal and remand." However, this case is from the Eighth Circuit and is non-binding on this Court.

In the Fifth Circuit, reversal is appropriate only if the applicant shows prejudice from the deficiencies she alleges.

Carey v. Apfel, 230 F.3d 131, 143 (5th Cir. 2000). Prejudice can be established by showing that additional evidence would have been produced if the ALJ had fully developed the record, and that the additional evidence might have led to a different conclusion. Newton, 209 F.3d at 458. As claimant has not shown that she was prejudiced by the ALJ's alleged failure to consider the letter, this argument lacks merit.

Finally, claimant asserts that the Appeals Council erred by issuing a standard form denial instead of specifically addressing her arguments. In support of this argument, claimant relies on *Newton*, 209 F.3d at 459, in which the Fifth Circuit referenced the *Hearings, Appeals and Litigation Law Manual* (HALLEX) Section I-3-501 (Nov. 11, 1994), which provided that the Appeals Council must "specifically address additional evidence or legal arguments or contentions submitted in connection with the request for review." However, this provision has since been abolished by HALLEX I-3-5-90 (July 20, 1995), which provides that: "[e]ffective immediately, we are temporarily suspending the requirement for a detailed discussion of additional evidence and for specific responses to contentions in denial notices." As claimant's request for review was denied, the Appeals Council was not required to give a detailed analysis for its decision. Thus, this argument also is without merit.

Based on the foregoing, it is my recommendation that the Commissioner's decision be AFFIRMED and that this action be DISMISSED with prejudice.

Under the provisions of 28 U.S.C. § 636(b)(1)(C) and F.R.Civ.Proc. 72(b), parties aggrieved by this recommendation have ten (10) business days from service of this Report and Recommendation to file specific, written objections with the Clerk of Court. A party may respond to another party's objections within ten (10) days after being served with a copy thereof. Counsel are directed to furnish a courtesy copy of any

objections or responses to the District Judge at the time of filing.

FAILURE TO FILE WRITTEN OBJECTIONS TO THE PROPOSED FACTUAL FINDINGS AND/OR THE PROPOSED LEGAL CONCLUSIONS REFLECTED IN THIS REPORT AND RECOMMENDATION WITHIN TEN (10) DAYS FOLLOWING THE DATE OF ITS SERVICE, OR WITHIN THE TIME FRAME AUTHORIZED BY FED.R.CIV.P. 6(b), SHALL BAR AN AGGRIEVED PARTY FROM ATTACKING THE FACTUAL FINDINGS OR THE LEGAL CONCLUSIONS ACCEPTED BY THE DISTRICT COURT,

EXCEPT UPON GROUNDS OF PLAIN ERROR. *DOUGLASS V. UNITED SERVICES AUTOMOBILE ASSOCIATION*, 79 F.3D 1415 (5TH CIR.1996).

Signed this 2nd day of January, 2004, at Lafayette, Louisiana.

S/C. MICHAEL HILL
UNITED STATES MAGISTRATE JUDGE

APPENDIX I:

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA
LAFAYETTE-OPELOUSAS DIVISION

IDA J. ROCHESTER	CIVIL ACTION
VERSUS	NO: 02-2114
JO ANNE B. BARNHART,	JUDGE DOHERTY
COMM. SSA	MAG. JUDGE HILL

JUDGMENT

This matter was referred to United States Magistrate Judge C. Michael Hill for Report and Recommendation. After an independent review of the record, including the objections filed herein, this Court concludes that the Report and Recommendation of the Magistrate Judge is correct and adopts the findings and conclusions therein as its own.

Accordingly, IT IS ORDERED, ADJUDGED AND DECREED that the Commissioner's decision is AFFIRMED and this matter is DISMISSED with prejudice.

Lafayette, Louisiana, this 2nd day of January, 2002 .

S/C. MICHAEL HILL
UNITED STATES MAGISTRATE JUDGE

APPENDIX J :

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 03-31055
Summary Calendar

MAXANN C. FINK,

Plaintiff-Appellant

versus

JO ANNE B. BARNHART,
COMMISSIONER OF SOCIAL SECURITY,

Devendant-Appellee

Appeal from the USDC for the Eastern District of LA
USDC No. 02-CV-2136

Consolidated With

No. 04-30121
Summary Calendar

IDA J. ROCHESTER,

Plaintiff-Appellant

versus

JO ANNE B. BARNHART,
COMMISSIONER OF SOCIAL SECURITY.

Defendant-Appellee

Appeal from the USDC for the Western District of LA
USDC No. 02-CV-2114

Before DAVIS, SMITH, and DENNIS, Circuit Judges.
PER CURIAM:[6]

Maxann C. Fink appeals the district court's judgment denying her motion for summary judgment, granting the Commissioner's cross-motion for summary judgment, and affirming the Commissioner's decision denying her applications for disability insurance benefits and supplemental security income (SSI) benefits. Ida J. Rochester appeals the district court's judgment affirming the Commissioner's decision denying Rochester's application for SSI benefits. The appeals have been consolidated. In reviewing the Commissioner's decisions to deny benefits, we must determine whether there is substantial evidence in the record to support the decisions and whether the proper legal standards were used in evaluating the evidence. *Ripley v. Chater*, 67 F.3d 552, 555 (5th Cir. 1995).

Fink argues that the Commissioner violated 20 C.F.R. § 404.1512(e)(1) and (f) by ordering a consultative examination (DE) without first recontacting the treating physicians for an explanation of any perceived discrepancies in the medical records. Both Fink and Rochester contend that the Commissioner also violated 20 C.F.R. § 404.1519h by failing to appoint a treating physician to perform the CE. Fink and Rochester next challenge the proceedings at their respective administrative hearings, arguing that the administrative law judges (ALJs) violated 20 C.F.R. §§ 404.1512(e) and 404.1527(d)(2) by failing to 1) recontact the treating physicians and 2) consider the necessary regulatory factors when declining to afford controlling weight to the treating physicians' opinions. Rochester also argues that the ALJ erred by failing to address the written statement of her sister.

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[6] Pursuant to 5th Cir. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5th Cir. R. 47.5.4.

Because Fink and Rochester were afforded the opportunity to supplement their respective records with additional medical reports from their treating physicians, we hold that any procedural errors committed by the Commissioner were harmless and did not affect Fink's or Rochester's substantial rights. *See Morris v. Bowen*, 864 F. 2d. 333 (5th Cir. 1988). Similarly, Fink's and Rochester's reliance upon *Newton v. Apfel* for purposes of their alleged ALJ procedural errors is misplaced since the records for both Fink and Rochester contained "other medical opinion evidence based on personal examination" in the form of CE reports, *See* 209 F.3d 448, 453 (5th Cir. 2000). Accordingly, we hold that the ALJs did not commit error when declining to afford controlling weight to the treating physicians' opinions. Finally, we reject Rochester's argument regarding the ALJ's failure to address her sister's written statement as conclusional and lacking merit.

The records reveal that the ALJs' decisions to deny benefits were supported by substantial evidence. *See Martinez v. Chater*, 64 F.3d 172, 173 (5th Cir. 1995).

Dated 1/31/05

APPENDIX K:

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 03-31055

MAXANN C. FINK,

Plaintiff-Appellant

versus

JO ANNE B. BARNHART,

Defendant-Appellee

No. 04-30121

IDA J. ROCHESTER,

Plaintiff-Appellant

versus

JO ANNE B. BARNHART,

Defendant-Appellee

- - - - - - - - - - - - - - -

Appeal from the USDC for the Eastern District of LA

- - - - - - - - - - - - - - -

ON PETITION FOR REHEARING EN BANC

PER CURIAM:

(X) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. No member of the panel nor judge in regular active service of the court having requested that the court be polled on Rehearing En Banc (Fed. R. App. P. and 5th Cir. R. 35), the Petition for Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

S/ Jerry Smith

United States Circuit Judge *Filed: 4/6/05*

APPENDIX L:

Sen. Levin's remarks, in context, follow:

One of the major causes of complaint and dissatisfaction with the disability review process has been SSA's reliance on its own purchased medical reports by doctors who give what are known as consultative exams. Beneficiaries claim repeatedly that these exams are only cursory, conducted by doctors who are not qualified in the necessary field of medicine, and are relied upon to the exclusion of the medical findings offered by the treating physician. Consultative exams are designed to be used by SSA only where there is conflicting medical evidence that it is necessary to resolve in order to make an eligibility determination. Instead, allegations abound that they are in fact ordered routinely, used as a counterpoint to the report of the treating physician, and relied upon almost exclusively.

By passing this legislation today, we are directing SSA to give great credence to the findings and reports of a beneficiary's treating physician who more often than not has lived closely with that subject's disabilities and through his/her hands-on experience has developed a more thorough knowledge of the illness than the consultative examiners who may give no more than 30 minutes for the evaluation.

SSA complains that treating physicians too often provide mere opinion without the necessary test results or specific medical findings upon which the disability examiner can make the necessary determination. This bill is telling SSA to ask the proper questions of the treating physician so it can elicit a helpful response. If there are tests to be conducted and scientific assessments made of an individual's functional capabilities, SSA should work with the treating physician to get those answers. Under the provision in this bill, we should witness far fewer consultative exams and more thorough and factually based reports by treating physicians.

(See Congressional Record - Senate, May 22, 1984, pp.13236-13237)

FILED
DEC 23 2005
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 05-58

In the Supreme Court of the United States

MAXANN C. FINK AND IDA J. ROCHESTER,
PETITIONERS

v.

JO ANNE B. BARNHART, COMMISSIONER
OF SOCIAL SECURITY

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether the court of appeals correctly held any procedural errors committed by the Administrative Law Judge in considering petitioners' Social Security disability claims were harmless error.

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In the Supreme Court of the United States

No. 05-58

MAXANN C. FINK AND IDA J. ROCHESTER,
PETITIONERS

v.

JO ANNE B. BARNHART, COMMISSIONER
OF SOCIAL SECURITY

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 82-84) is not published in the Federal Reporter but is reprinted in 123 Fed. Appx. 146. The orders and judgments of the district courts (Pet. App. 49-50, 81) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on January 31, 2005. A petition for rehearing en banc was denied on April 6, 2005 (Pet. App. 85). The petition for a writ of certiorari was filed on July 5, 2005. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Petitioners sought disability benefits under Title II of the Social Security Act, 42 U.S.C. 423, and supplemental security income (SSI) under Title XVI of the Social Security Act, 42 U.S.C. 1381 *et seq.* At issue here is the role of treating physicians in the consideration of disability claims by the Social Security Administration (SSA).

1. Petitioner Maxann C. Fink sought disability and SSI benefits for back and neck problems associated with ruptured disks. Pet. App. 20. The administrative law judge (ALJ) denied these benefits, finding that "there are jobs existing in significant numbers in the national economy that [petitioner Fink] is capable of performing and has been capable of performing since her alleged onset date." *Id.* at 16. The Appeals Council denied petitioner Fink's request for review, and the ALJ's decision became the SSA's final decision. *Id.* at 17-19.

Petitioner Fink sought judicial review in the District Court for the Eastern District of Louisiana. In a comprehensive report recommending that the district court grant SSA's motion for summary judgment (Pet. App. 20-48), the magistrate judge concluded that substantial evidence supported the ALJ's decision. The magistrate rejected petitioner Fink's claims that SSA erred (1) by failing to recontact her treating physician before ordering a consultative examination, (2) by ordering a consultative examination without soliciting the treating physician to perform the examination, (3) by providing the consultative examination report to the medical expert without recontacting the treating physician, and (4) by rejecting the findings of the treating physician without attempting to recontact them. *Id.* at 37-38.

Upon review of the administrative record, the magistrate judge concluded that SSA had "complied with the regulations in contacting the health care providers identified by Fink." Pet. App. 41. The magistrate judge further concluded that SSA's decision to request a consultative examination with someone other than her treating physician was not an abuse of discretion, given that her treating physician had "failed to respond to the Commissioner's initial request for a statement of [petitioner] Fink's ability to perform work-related physical activities." *Id.* at 43. Although the magistrate judge concluded that SSA should have made a follow-up request to petitioner Fink's treating physician, the magistrate judge concluded that that lone procedural error did not cast doubt on the ALJ's decision, given that petitioner Fink had obtained additional information from her treating physicians and had furnished that information to the medical expert in advance of the hearing before the ALJ. *Id.* at 42, 43-44, 46. Finally, the magistrate judge sustained the ALJ's rejection of the opinions of the treating physicians on the ground that the ALJ had reliable medical evidence from the consulting physician, who had examined petitioner Fink, that controverted the opinions of the treating physicians. *Id.* at 47-48.

The district court adopted the magistrate judge's report and recommendation as its opinion, and it granted SSA's motion for summary judgment. Pet. App. 49-50.

2. Petitioner Ida J. Rochester sought SSI benefits based on an alleged disability due to mental illness, Pet. App. 51, specifically "chronic panic attacks and paranoia." *Id.* at 53. The ALJ denied petitioner Rochester's request for benefits. *Id.* at 58. The ALJ found that,

although petitioner Rochester suffered from panic attacks, she did not suffer from a disabling mental or physical impairment within the meaning of the SSI regulations, and that there were jobs existing in significant numbers in the economy that petitioner Rochester remains capable of performing. *Id.* at 55-57. The Appeals Council, after vacating an initial denial of review in order to consider additional arguments, denied petitioner Rochester's request for review, and the ALJ's decision became the SSA's final decision. *Id.* at 60-62.

Petitioner Rochester sought judicial review in the District Court for the Eastern District of Louisiana. In a comprehensive report (Pet. App. 63-72), the magistrate judge recommended affirmance of the ALJ's decision. In so doing, the magistrate judge rejected, *inter alia*, petitioner Rochester's contentions that the ALJ erred (1) in rejecting the findings of the treating psychiatrists without recontacting them and without giving appropriate weight to the treating relationship, (2) in substituting his medical assessment for that of the treating psychiatrists; and (3) in ordering a consultative examination without attempting to have it performed by a treating psychiatrist. See *id.* at 72-73.

The magistrate judge reasoned that the ALJ did not need to recontact petitioner Rochester's treating psychiatrists before rejecting their opinion because the ALJ had available other medical opinion evidence—that of the consulting psychiatrist—which was "based on personal examination or treatment of the claimant." Pet. App. 73 (citing *Newton* v. *Apfel*, 209 F.3d 448 (5th Cir. 2000)) (emphasis omitted); see also Pet. App. 69-70 (indicating petitioner Rochester submitted to the ALJ additional information from her treating physician). The magistrate judge further concluded that the ALJ did not

err in giving greater weight to the consulting psychiatrist's opinion than to that of the treating psychiatrists, given that the latter was based largely on petitioner Rochester's self-reports, which the evidence demonstrated were unreliable. *Id.* at 73-75; see *id.* at 65 (noting consulting psychiatrist's observation that many of the notes in petitioner Rochester's medical records indicated that "she was lazy and did not particularly care to work and that she was certainly seeking being placed on SSI benefits"). In addition, the magistrate judge concluded that no regulations required SSA to use the treating physician as the only consulting physician. *Id.* at 77-78.

The district court adopted the magistrate judge's report and recommendation as its opinion, and it affirmed the denial of benefits. Pet. App. 81.

3. The Fifth Circuit consolidated petitioners' appeals and affirmed in a short, unpublished per curiam. Pet. App. 82-84.

Petitioner Fink argued that SSA had violated 20 C.F.R. 404.1512(e)(1) and (f) by ordering a consultative examination "without first recontacting the treating physicians for an explanation of any perceived discrepancies in the medical records." Pet. App. 83. Both petitioners argued that SSA violated 20 C.F.R. 404.1519h by "failing to appoint a treating physician to perform" the consultative examination. *Ibid.* Finally, both petitioners contended that the ALJs violated 20 C.F.R. 404.1512(e) and 404.1527(d)(2) by "failing to 1) recontact the treating physicians and 2) consider the necessary regulatory factors when declining to afford controlling weight to the treating physicians' opinions." *Ibid.*

The court of appeals rejected petitioners' contentions. Because petitioners Fink and Rochester "were

afforded the opportunity to supplement their respective records with additional medical reports from their treating physicians," the court held "that any procedural errors committed by the Commissioner were harmless and did not affect [petitioners'] substantial rights." Pet. App. 84 (citing *Morris* v. *Bowen*, 864 F.2d 333 (5th Cir. 1988)). The court of appeals further held that the ALJs did not err in declining to give controlling weight to the treating physicians' opinions. *Ibid.* The court distinguished its decision in *Newton*, *supra*, where it held that the ALJ had improperly rejected the opinion of the treating physician in the absence of contradictory evidence from physicians who had examined or treated the claimant and without requesting additional information from the claimant's treating physician. 209 F.3d at 460. The court here explained that, unlike in *Newton*, "the records for both Fink and Rochester contained 'other medical opinion evidence based on personal examination' in the form of [consultative examination] reports." Pet. App. 84 (quoting *Newton*, 209 F.3d at 453).

ARGUMENT

The per curiam decision of the court of appeals is unpublished and establishes no precedent that will control any future cases. Moreover, the decision is correct and does not conflict with any decision of this Court or that of any other court of appeals. The petition for a writ of certiorari therefore should be denied.

1. Based on the facts of these respective cases, the court of appeals concluded that the ALJs did not err in rejecting the opinions of petitioners' treating physicians, and that any procedural error in failing to recontact the treating physicians or in failing to engage those physicians for the consultative examination was harmless be-

cause both petitioners were afforded the opportunity to provide additional information from those physicians. That factbound decision is correct and does not warrant further review.

a. Petitioners' principal argument (Pet. 8-24) appears to be that the statute, 42 U.S.C. 423(d)(5)(B), and SSA regulations impose mandatory duties upon an ALJ with respect to obtaining and considering evidence from treating physicians, and that any failure to comply strictly with those purported duties, regardless of the factual circumstances, requires a remand to the agency for a rehearing. The plain text of the statute and of the regulations refutes that argument.

The statutory provision upon which petitioners rely, 42 U.S.C. 423(d)(5)(B), states merely that the Commissioner "shall make *every reasonable effort* to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, *prior to evaluating* medical evidence obtained from any other source on a consultative basis." 42 U.S.C. 423(d)(5)(B) (emphasis added). The Commissioner's regulations define "every reasonable effort" as meaning "that we will make an initial request for evidence from your medical source and * * * if the evidence has not been received, we will make one followup request to obtain the medical evidence necessary to make a determination." 20 C.F.R. 404.1512(d)(1). That definition defeats petitioners' claim that "every reasonable effort" means that the Commissioner "must try every reasonable means to base its determination on the findings and opinions of the treating physicians until it can be fairly said that it would be un-

reasonable to ask it to make further effort." Pet. 11 (emphasis omitted).

Moreover, contrary to petitioners' contentions (*e.g.*, Pet. 19), neither Section 423(d)(5)(B) nor the regulations impose a mandatory duty to recontact the treating physician in all circumstances. The regulations accord the Commissioner a measure of discretion over the decision to recontact, providing that "[w]e may not seek additional evidence or clarification from a medical source when we know from past experience that the source either cannot or will not provide the necessary findings." 20 C.F.R. 404.1512(e)(2). Indeed, the recontacting provision, 20 C.F.R. 404.1512(e)(1), applies only when, in the judgment of the finder of fact, "the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques."

The lack of an inflexible requirement is also evident in 20 C.F.R. 404.1519h, the provision concerning the use of the treating physician in a consultative examination. That provision provides that "[w]hen in our judgment your treating source is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment, and generally furnishes complete and timely reports, your treating source will be the preferred source to do the purchased examination." This language expressly endows the Commissioner with substantial discretion in making a decision that will necessarily differ from case to case depending on the facts; it does not create (as petitioner suggests, *e.g*, Pet. 15) a mandatory requirement that the treating physician be employed for the consultative examination.

Petitioners also err in arguing (Pet. 15) that 20 C.F.R. 404.1527(d)(2) imposes a mandatory duty to make findings on each factor set forth therein when considering what weight to give the opinion of the treating physician. That section specifies factors for the ALJ to consider, but the ultimate duty imposed by the regulation is only that the ALJ "give good reasons" in determining the weight to be accorded to the treating physician's opinion. See 20 C.F.R. 404.1527(d)(2). The sufficiency of the reasons given is obviously fact-bound and will necessarily vary from case to case.[1]

b. In any event, the first question presented by the petition is simply whether the court below erred in concluding that any procedural error committed by SSA in failing to comply with 20 C.F.R. 404.1527(d)(2) was harmless error. Pet. ii. But the court of appeals did not even apply a harmless error analysis to that claim of petitioners; instead, it held that the ALJs had complied with Section 404.1527(d)(2). The court of appeals stated: "we hold that the ALJs did not commit error when declining to afford controlling weight to the treating physi-

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[1] Petitioners appear to assume that 20 C.F.R. 404.1527(d)(2) is an implementation of Section 423(d)(5)(B). That is incorrect. Section 423(d)(5)(B) pertains to evidence gathering. Section 404.1527(d)(2) pertains to how the Commissioner weighs evidence. The two are different. The Senate Finance Committee, in its consideration of the provision that became Section 423(d)(5)(B) (Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, § 9, 98 Stat. 1804), indicated in its report that it did "not intend to alter in any way the relative weight which the Secretary places on reports received from treating physicians and from consultative examinations." S. Rep. No. 466, 98th Cong., 2d Sess. 26 (1984). The Committee further noted: "Nor is it intended that the Secretary shall be precluded from obtaining consultative examinations when the Secretary finds it necessary to secure additional information or to resolve conflicting evidence." *Ibid.*

cians' opinions." Pet. App. 84. Even assuming the court of appeals' harmless-error holding applies to petitioners' Section 404.1527(d)(2) claim, that factbound decision is correct. Petitioners in this case have not contended, and could not reasonably contend, that the ALJs in these cases did not give "good reasons" for their findings regarding the treating physicians' opinions, including reliance on medical evidence from examining physicians that controverted the opinions of the treating physicians. Pet. App. 47-48 (magistrate judge's recommendations regarding petitioner Fink); *id.* at 73-75 (same as to petitioner Rochester).

To be sure, the court of appeals did apply a harmless error analysis to petitioners' separate contentions (1) that there was error at the prehearing stage because SSA ordered a consultative examination without recontacting the treating physician, 20 C.F.R. 404.1512(e)(1) and (f), and failed to employ the treating physicians for the consultative examinations under Section 404.1519h, and (2) that the ALJs erred in failing to recontact the treating physicians under Section 404.1512(e) and (f). See Pet. App. 83-84. But to the extent the first question presented encompasses those claims, they do not warrant review either. The court of appeals properly concluded that, on the particular facts presented in these two cases, any procedural errors at the prehearing stage were harmless because both petitioners had a subsequent opportunity to present supplemental medical reports from their treating physicians to the ALJs. *Id.* at 84. The court's harmless error analysis was thus case-specific and factbound. Tellingly, petitioners do not assert that the court of appeals' factual assessment was in error or that there was substantial evidence of disability overlooked by the ALJs because of the alleged proce-

dural errors at the initial, pre-ALJ stages of the administrative review process.

For similar reasons, a failure by an ALJ to recontact a treating physician before considering a consultative examination that was ordered at a prehearing stage should not furnish a basis for setting aside the ALJ's decision. The contrary rule petitioners propose would in effect impose an exclusionary rule on ALJ proceedings, requiring the ALJ to ignore probative evidence in the record on the ground that SSA erred in requesting it in the first place. Petitioners cite no authority for such an extraordinary rule in administrative hearings. Because the ALJ conducts a de novo hearing and review based on all the evidence of record, procedural errors committed at the initial, more informal stages of the review process therefore should not ordinarily furnish a basis for challenging the ALJ's decision.

Furthermore, contrary to the contention raised by the second question framed in the petition (Pet. App. ii, 24-25), the court of appeals' holding does not purport to shift the task of obtaining additional information to the claimant. In these cases, additional information in fact *was* submitted by treating physicians to the ALJ. See *id.* at 42, 43-44, 46, 69-70; pp. 3, 4-5, *supra*. Petitioners thus were not prejudiced by the ALJ's alleged failure to request that same information.[2] Petitioners do not claim that there was still more information that could have

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[2] As such, contrary to petitioners' contention (Pet. 24-26), the decision below does not conflict with decisions in the Tenth Circuit suggesting that the ALJ bears the responsibility of seeking additional information, where necessary, from the treating physician. See *Robinson* v. *Barnhart*, 366 F.3d 1078, 1084 (2004); *White* v. *Barnhart*, 287 F.3d 903, 908 (2001).

been obtained if the ALJ had recontacted the treating physicians directly.

2. Petitioners contend (Pet. 6-7) that the court of appeals' holding that any procedural error was harmless conflicts with decisions of other courts of appeals. Petitioners are mistaken.

Only one of the decisions relied upon by petitioners discusses the possible applicability of "harmless error" principles. That decision, *Wilson* v. *Commissioner of Social Security*, 378 F.3d 541 (6th Cir. 2004), is not contrary to the decision below. In *Wilson*, the ALJ had rejected the opinion of the treating physician without articulating any "good reasons" for doing so. *Id.* at 545. Although the Sixth Circuit concluded, on the facts of that case, that the ALJ's failure to provide reasons for rejecting the treating physician's opinion was not "harmless error," *id.* at 546, the Sixth Circuit expressly noted that "[t]hat is not to say that a violation of the procedural requirement of § 1527(d)(2) could never constitute harmless error." *Id.* at 547. Moreover, the Sixth Circuit indicated that one possible example of harmless error could be a situation "where the Commissioner has met the goal of § 1527(d)(2)—the provision of the procedural safeguard of reasons—even though she has not complied with the terms of the regulation." *Ibid.*

That decision is not inconsistent with the decision below. Here, unlike in *Wilson*, the ALJs did provide good reasons for rejecting the treating physicians' opinions. There is nothing in *Wilson* that would preclude the Sixth Circuit from reaching the same conclusion as the Fifth Circuit in this case in the circumstances presented here. See 378 F.3d at 547. In contrast, the government's "harmless error" contention in *Wilson* was

merely that "the ALJ 'could' have relied on evidence in the record." *Id.* at 546.

Moreover, there is good reason to believe that the outcome of *Wilson* would have been the same in the Fifth Circuit as it was in the Sixth. In *Wilson*, the Sixth Circuit relied upon the Fifth Circuit's decision in *Newton*, *supra*, for the proposition that "courts have remanded the Commissioner's decisions when they have failed to articulate 'good reasons' for not crediting the opinion of a treating source, as § 1527(d)(2) requires." *Wilson*, 378 F.3d at 545 (citing *Newton*, 209 F.3d at 456). The decision below did not retreat from *Newton*, but merely distinguished it on the ground that in *Newton*—as was apparently the case in *Wilson* as well—the record did not contain any medical opinion evidence that was based on a personal examination of the claimant other than the opinion of the treating physician.

Petitioners' claim that the decision below conflicts with decisions in other circuits is similarly without merit. Although petitioners do cite cases (*e.g.*, Pet. 6-7) in which other courts of appeals have remanded for reconsideration on the grounds that the ALJ failed to give "good reasons" for rejecting a treating physician's opinion or failed to seek additional information from a treating physician, none of those decisions holds that such a procedural error could never be harmless. Any such rigid rule would be inconsistent with the generally applicable principle of administrative law that a reviewing court should set aside an agency decision only if any errors the court identifies were prejudicial. See, *e.g.*, 5 U.S.C. 706 (reviewing court shall take "due account" of the "rule of prejudicial error"). Rather, the cases on which petitioners rely were factbound resolutions based on the application of legal principles that do not conflict

with those applied by the decision below.[3] Indeed, like other circuits, the Fifth Circuit has vacated and remanded cases on similar grounds. See, *e.g.*, *Newton*, 209 F.3d at 460 (remanding to the ALJ for further consideration after concluding that the ALJ "improperly rejected the opinions of [the claimant's] treating physician without contradictory evidence from physicians who had examined or treated [the claimant] and without request-

[3] See *Robinson*, 366 F.3d at 1083-1084 (remanding where the ALJ failed to give "any explanation" for how he assessed the weight of the treating physician's opinion, failed to seek additional information from that physician after the ALJ concluded that the physician's information was inadequate, and rejected the treating physician's opinion in favor of the opinion of a physician who had not examined the claimant); *O'Donnell* v. *Barnhart*, 318 F.3d 811, 816, 818 (8th Cir. 2003) (remanding for the ALJ to seek additional information from the treating physician where the ALJ gave "no weight" to the physician's opinion after finding that the physician's treatment notes were "conclusory," and where the claimant's treating physician had additional relevant information to submit); *Bowman* v. *Barnhart*, 310 F.3d 1080, 1085 (8th Cir. 2002) (remanding to the ALJ to seek additional information from the treating physician where the ALJ rejected the treating physician's opinion in favor of the opinion of a physician who had not examined the claimant); *Clark* v. *Commissioner of Soc. Sec.*, 143 F.3d 115, 118-119 (2d Cir. 1998) (remanding to the district court to reconsider the claimant's contention that the ALJ should have sought additional information from the treating physician before rejecting his opinion based on a lack of clinical or objective support in his records); *Goatcher* v. *United States Dep't of Health & Human Servs.*, 52 F.3d 288, 290 (10th Cir. 1995) (remanding where the ALJ gave "short shrift" to the treating physician's opinion and failed to give "specific, legitimate reasons" for doing so). See also *White*, 287 F.3d at 907-908 (holding that the ALJ did not err in rejecting the treating physician's opinion in favor of that of a consulting physician who had examined the claimant, noting that the ALJ gave good reasons for doing so, and holding that the ALJ did not err in failing to recontact the treating physician where the information that the treating physician provided was "not so incomplete that it could not be considered").

ing additional information from the treating physician"). The published decision in *Newton*, not the unpublished decision in this case, constitutes the relevant Fifth Circuit precedent on this issue. There is no reason to believe that the Fifth Circuit will not continue to vacate and remand when there are prejudicial procedural errors, just as it did in *Newton* and as other courts of appeals have done.

3. Finally, petitioners broadly assert (Pet. 5) that SSA routinely ignores the regulations relating to treating physicians. SSA processes literally millions of disability claims each year;[4] roughly 100,000 claims are resolved each year by the Appeals Council.[5] That errors occur in particular cases is regrettable, but inevitable as a practical matter. The Appeals Council sits to correct such errors and, as petitioners acknowledge, it has done so in cases with respect to the same types of errors alleged here. Pet. 18 ("Counsel for petitioners has obtained a number of remands from the Appeals Council for failure to comply with 20 CFR 404.1512(e)(1)."). In any event, as the magistrate judges' opinions in these cases make clear, there is substantial evidence demonstrating that petitioners were not disabled within the meaning of the Social Security Act.

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[4] See 70 Fed. Reg. 43,590 (2005) ("Currently, more than two and a half million individuals apply for Social Security and SSI benefits based on disability each year.").

[5] See SSA, *Annual Statistical Supplement, 2005* (Dec. 2005) <http://www.socialsecurity.gov/policy/docs/statcomps/supplement/2005/2f8-2f11.html#table2.f11>.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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